California Department of Mental Health Cultural Competence Plan Requirements

COVER SHEET

An original, three copies, and a compact disc
of this report (saved in PDF [preferred]
or Microsoft Word 1997-2003 format)
due July 28, 2010 to:

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, CA 95814

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Name of County Mental Health Director: Michael Kennedy, LMFT

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CHECKLIST OF THE 2010 CULTURAL CPMPETENCY PLAN REQUIREMENTS CRITERIA

√ CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE
√ CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS
√ CRITERION 3: STRATEGIES AND EFFORS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES
√ CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGERATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM
√ CRITERION 5: CULTUALLY COMPETENT TRAINING ACTIVITES
√ CRITERION 6: COUNTY'S COMMITTEMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF
√ CRITERION 7: LANGUAGE CAPACITY
√ CRITERION 8: ADAPTATION OF SERVICES

CRITERION 1

COUNTY MENTAL HEALTH SYSTEM
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR.

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

The county shall have the following available on site during the compliance review:

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policies and Procedure Manuals;
5. Human Resources Training and Recruitment Policies;
6. Contract Requirements; and
7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted in the CCPR.

The county shall include the following in the CCPR:

A. A description, not to exceed two pages, of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Pages 27-32 of the Sonoma County Department of *Mental Health Services – Behavioral Health Division 2017-2020 Three-Year Integrated Plan & Annual Update for 2015-2016* describe the practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities.

The *2017-2020 Three-Year Integrated Plan & Annual Update for 2015-2016* can be found using the following link: http://www.sonoma-county.org/health/about/pdf/mhsa/2017-2020-MHSA-integrated-plan.pdf.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of racial, ethnic, cultural and linguistically diverse clients, family members, advisory committees, local mental health boards, and commissions, and community organization in the mental health planning process of services.

Beginning on page 8 of the Sonoma County Department of Mental Health Services – Behavioral Health Division *2017-2020 Three-Year Integrated Plan & Annual Update for 2015-2016* describe the county stakeholder mental health planning process for services provide through Mental Health Services Act which includes services provided by Sonoma County Mental Health Plan.

The Plan Update and Annual Update for 2014-2015 can be found using the following link: http://www.sonoma-county.org/health/about/pdf/mhsa/2016-2017-mhsa-plan-update.pdf.

C. A narrative, not to exceed two pages, discussing how the county is working on skill development and strengthening of community organization involved with essential services.

In Sonoma County's ongoing commitment to serve disparate communities, the Division contracted with a local consulting firm, Kawahara & Associates. Kawahara & Associates specializes in program and organizational development providing individualized technical assistance to grass-roots organizations and nascent programs that served the African American, Latino/Hispanic, Native American and LGBTQ communities. In Sonoma County, 4 organizations were funded through PEI that, for Sonoma County, represent organizations that provide essential services to communities of color and other cultural groups. These organizations serve a key role in reducing stigma and discrimination about mental health in these diverse communities and provide necessary outreach to these historically underserved communities. These Sonoma County organizations are: Latino Service Providers, Community Baptist Church, Sonoma County Indian Health Project, and Positive Images.

On July 11, 2016, the California Department of Public Health (CDPH) announced an intent to award $13 million in grants to California Reducing Disparities Pilot Projects to help reduce mental health disparities in communities that have traditionally been underserved, including

African Americans, Asian Americans, Latinos, Native Americans and LGBT+ communities. The primary goal of the project is to validate community-defined evidence practices through rigorous evaluation.

Of the four PEI Reducing Disparities MHSA contractors (Latino Service Providers, Community Baptist Collaborative, Sonoma County Indian Health Project, & Positive Images), three agencies submitted applications to CDPH/Office of Health Equity (OHE) for the California Reducing Disparities Project (CRDP) funding specific to their communities. Of those three submissions, two providers, Latino Service Providers (LSP) and Sonoma County Indian Health Clinic (SCIHP), were awarded a $1.14 million five-year grant to implement a community-defined evidence practice in the Latino and Native American communities respectively.

This infusion of OHE funding will leverage statewide MHSA funding to enhance, expand, and sustain Prevention and Early Intervention services in Sonoma County.

Kawahara & Associates continues to support these projects with evaluation and capacity building technical assistance. Based upon the early foundations built by the PEI Reducing Disparities Initiative started in 2009, Sonoma County is well positioned to be part of this unprecedented statewide project with CDPH.

D. Share lessons learned on efforts made on items, A, B, and C above.

The Division has both formal and informal ways to collect feedback and input. Acknowledging the informal networks is an important way to get information and build bridges with communities of color and other disparate communities. The Behavioral Health Director and senior staff prioritize meetings with individual community members or small groups in order to obtain all feedback and input. Furthermore, Behavioral Health staff participate in various meeting and gatherings that target communities of color and other disparate communities.

E. Identify county technical assistance needs.
N/A

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for the cultural competence.

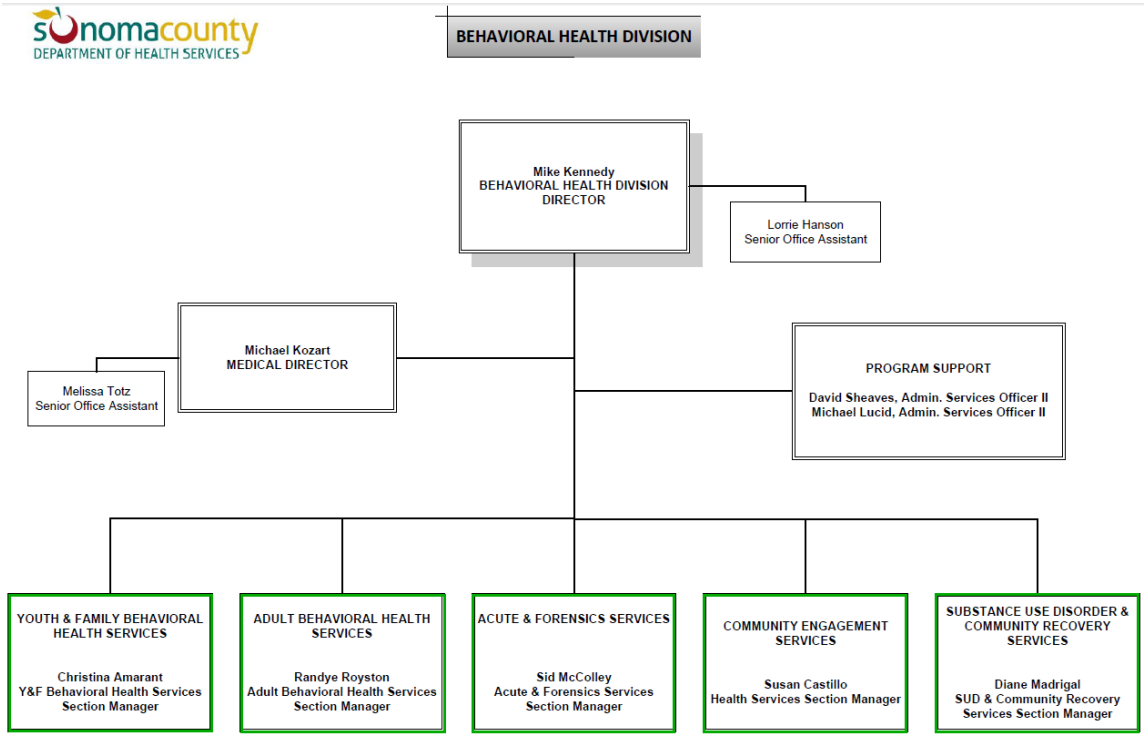
The CC/ESM will report to and/or have direct access to the Behavioral Health Director regarding issues impacting behavioral health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

The county shall include the following in the CCPR:

A. Evidence the County Mental Health System has designated CC/ESM who is responsible for the cultural competence and promotes the development of

appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

The Community Engagement Services Health Services Section Manager is the designated CC/ESM for Sonoma County Health Plan. Below is Sonoma County Mental Health Plan (MHP) organizational chart that demonstrates the level of responsibility for the CC/ESM who is able to promote the development of appropriate mental health services that meet the diverse needs of Sonoma County's racial, ethnic, cultural, and linguistic populations:



B. Written description for the cultural competence responsibilities of the designated CC/ESM.

The Sonoma County CC/ESM uses the California Behavioral Health Directors Association (CBHDA) April 2016 *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services* as the basis for the implementation of CC-ESM responsibilities.

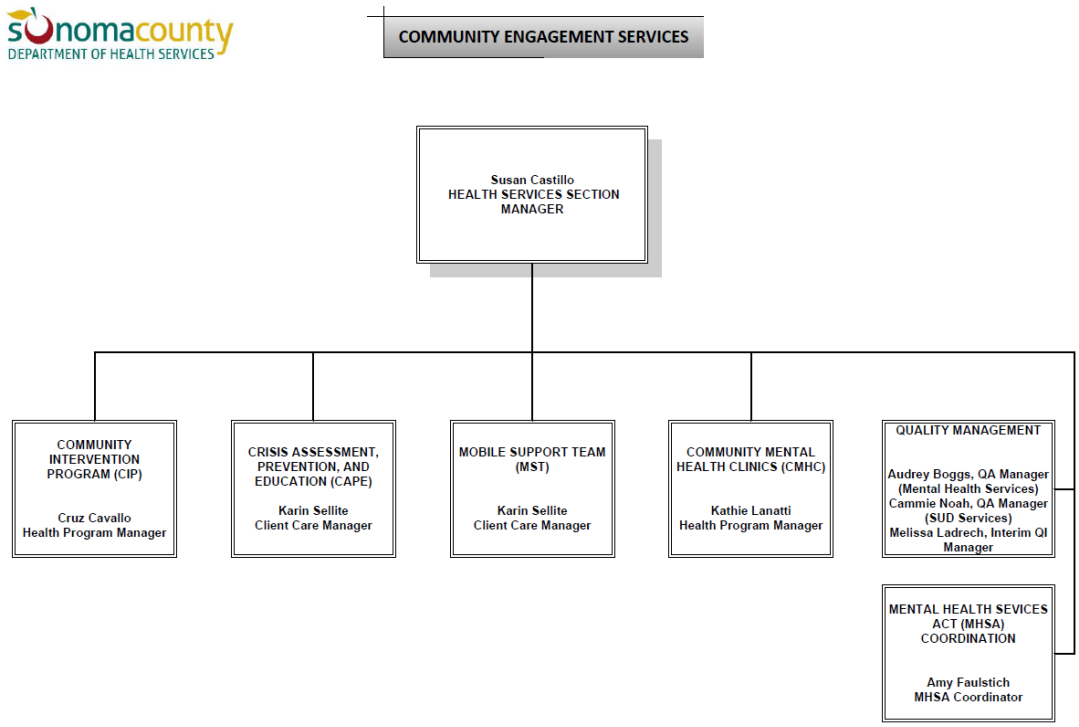
This document can be found using the following link: http://www.cbhda.org/wp-content/uploads/2015/06/CBHDA_ESM_Framework_Rev_2016_v7_FINAL_4-28-16.pdf.

As well, Sonoma County has developed the following grid to outline the description of the responsibilities and activities of the CC/ESM:

Areas of Responsibility	Activity
Responsible for development and implementation of cultural competency plan within Sonoma County Mental Health (SCMH)	• Attend Quality Improvement Steering Committee (QIS) to assist in the development of the Cultural Competency Plan • Attend Quality Improvement Policy Committee (QIP) as needed to assist in the development of an implementation plan
Participate in monitoring of county and service contractors to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations	• Ensure local and State mandates for service delivery of underserved population language is included in all contracts • Develop evaluation tools for assessing compliance with mandates of contracted organizations
ID local and regional cultural mental health needs of ethnically and culturally diverse populations as they impact county systems of care and make recommendations to SCMH Director, CMHDA, and the State Department of Mental Health	• Meet regularly with community groups and providers working specifically with ethnically and culturally diverse populations (Federally Qualified Health Clinics, La Luz, etc.) to ID local and regional cultural mental health needs of ethnically and culturally diverse populations • Meet regularly with QIP to report findings
Participate and advise on planning, policy, compliance and evaluation components of county system of care and make recommendations to SCBH director that assure access to services for ethnically and culturally diverse groups	• Oversight of Quality Management for MHP
Promote development of appropriate mental health services that will meet the diverse needs of the county's racial and ethnic populations.	• Develop language to be included in requests for proposals • Meet with mental health advisory groups (e.g. Latino Service Providers Meeting, etc.) • Facilitate training to SCBH and community providers
Assist in the formulation of the foundation of the county's delivery of mental health services to ethnic minorities	• Participate in the development of planning documents, contracts, proposals and grant applications

Participate as a member of SCMH senior management team about program and procedure policy recommendations	• Attend Quality Improvement Policy meetings to discuss program and policy recommendations
Review and critique materials generated at the State and local levels including but not limited to, proposed legislation, State plans, policies and other documents	• Attend regularly scheduled Ethnic Service Manager meetings • Review materials
Track penetration and retention rates of racially and ethnically diverse populations, and develop strategies to eliminate disparities	
Participate in the cultivation of network organizations to promote an array of mental health programs and activities that are specific to underserved populations	
Maintain an active advocacy, consultative, and supportive relationship with consumer and family organizations, local planning boards, advisory groups, and task forces, the State, and other mental health advocates	
Work with the county's Human Resources office to help ensure that the workforce is ethnically, culturally and linguistically diverse. Assist the Equal Employment Opportunity Office to ensure the recruitment, retention, and upward mobility of staff	
Assist in the development of system-wide training that addresses enhancement of workforce development and address the training necessary to improve quality of care for all communities and reduce mental health disparities	• Attend QIS to provide consultation to Training Committee provide guidance and input to address system-wide training
Attend trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system	• Identify trainings for EMS and other staff that will inform, educate, and develop skills
Attends meetings as required by the positions	• CMHDA Ethnic Services , Full Associations, regional ESM regular meetings, other committee meetings, various State meetings, meetings convened by various advisory bodies, and other meetings as appropriate

The organizational chart below demonstrates that the scope of responsibilities of the Community Engagement Services Health Services Section Manager oversight for the activities related to those of the CC/ESM. This included both services focused on outreach and engagement as well as Quality Management for the MHP.



IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

Expenditures for Cultural Competency Activities	
Organization/Priority Population	FY 16/17
CTS: Language Line/Non English Speakers	21,602
Latino Service Providers/Latinos	149,727
Sonoma County Indian Health Project/Native Americans	195,790
Positive Images/LGBTQQI	62,548
Community Baptist Church Collaborative /African Americans	161,502
Santa Rosa Community Health Centers/Communities of Color	591,553
Alliance Health Center/Latinos	10,236
West County Health Services /LGBTQQI	83,220
Alexander Valley Health Center/Latinos	69,000

Sonoma County Behavioral Health Division: Community Intervention Program	1,400,254.96
Cultural Competency Activities Oversight	41,557.00
Kawahara Associates, Inc. – Sonoma County Reducing Disparities Projects	20,000

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

1. Interpreter and translation services
2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
3. Outreach to racial and ethnic county identified target populations;
4. Culturally appropriate mental health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers. N/A

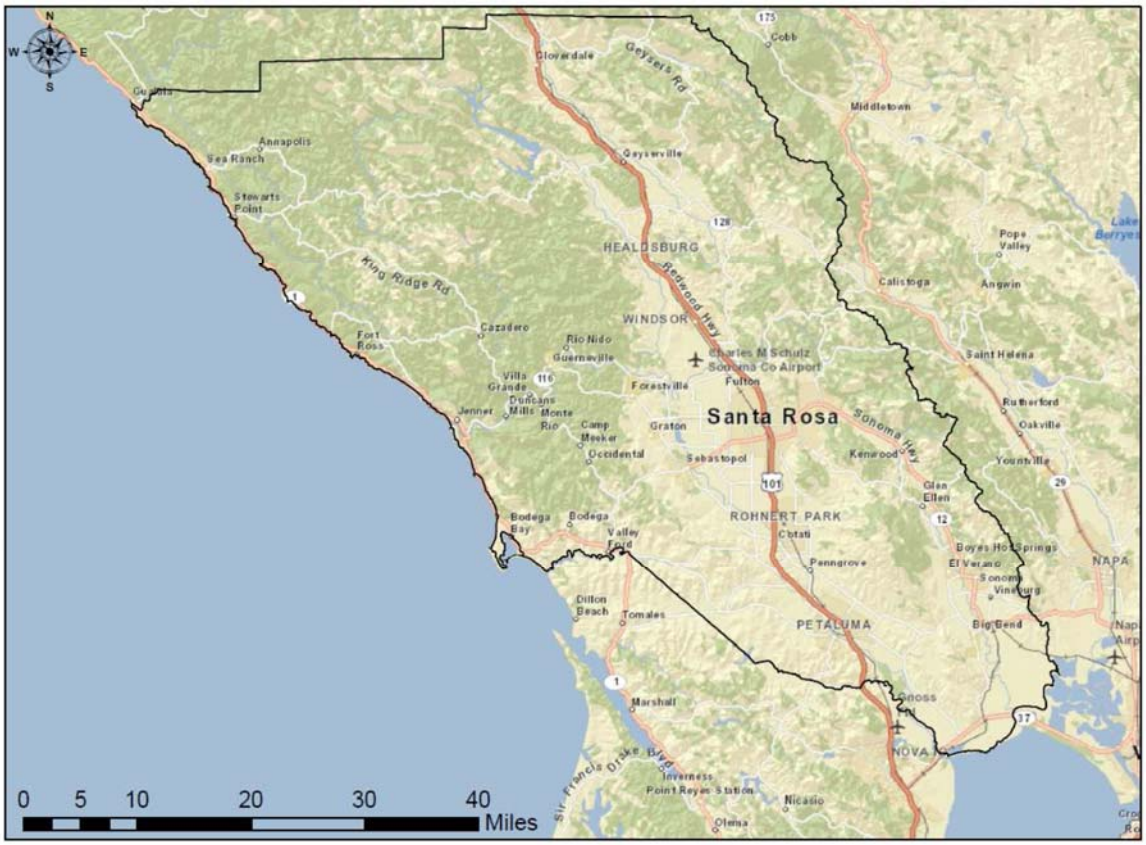
Agency/Organization ↓	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
CTS: Language Line/Non English Speakers	√			
Latino Service Providers/Latinos		√	√	
Sonoma County Indian Health Project/ Native Americans		√	√	√
Positive Images/LGBTQQI		√	√	
Community Baptist Church Collaborative/ African Americans		√	√	
Santa Rosa Community Health Centers/ Communities of Color		√	√	√
Alliance Health Center/Latinos	√	√	√	√
West County Health Services/ LGBTQQI		√	√	√
Alexander Valley Health Center/Latinos	√	√		
Sonoma County Behavioral Health Division: Community Intervention Program	√	√	√	√
Cultural Competency Activities Oversight		√		√
Kawahara Associates, Inc. – Sonoma County Reducing Disparities Projects		√		

CRITERION 2
COUNTY MENTAL HEALTH SYSTEM
UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

A. Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally.

Sonoma County measures 1,576 square miles and is the largest and northernmost county in the San Francisco Bay Area. In 2015, Sonoma County had the 17th largest county population of the 58 counties in California, with an estimated 502,000 residents (approximately 318 people per square mile).(1) According to 2015 U.S. Census Bureau estimates, Santa Rosa - the county seat and largest city - is home to about 35% of the total population and ranks as the 28th largest city in the state.(2,3) The majority (70%) of Sonoma County residents live within nine separate cities, with the remainder living within the unincorporated areas of the county. Sonoma County's population grew 3.8% from 483,880 people in 2010 to 502,000 in 2015.



In 2015, about 20% of Sonoma County's population was under 18 years old, 5% of whom were 0-5 years of age. More than 24% were 60 years and older. (4) The median age was 41 years old in 2015. By the year 2030, nearly 31% of the total population of Sonoma County will be aged 60 or older. (5,6) Although the racial/ethnic composition is changing, Sonoma County is still substantially less diverse than the state as a whole. In 2015, 64% of Sonoma County residents were White/Caucasian, non-Hispanic or Latino; 26% were Hispanic or Latino, 4% were Asian or Pacific Islander, 2% were African American, and 2% were American Indian or Alaska Native.(2) An estimated 17% of Sonoma County residents were foreign born. The total Hispanic or Latino population increased by over 300% in the past 20 years, and is projected to grow at a rate three times faster than the overall population in Sonoma County. By 2060, the Hispanic or Latino population is estimated to increase by approximately 100,000 people. (7) This increase has cultural and linguistic implications with regards to designing effective governmental programs and community-based initiatives.

The economic and housing landscape also continues to evolve in Sonoma County. Higher costs of living and increasing residential and commercial rents are fueled by job growth and the attractive quality of life in Sonoma County. In 2015, an estimated 87% of Sonoma County's population aged 25 years and older had a high school diploma or pursued higher education. While the median household income of Sonoma County residents in 2015 was approximately $67,000, over 52% of Sonoma County residents paid 30% or more of their gross income on rent.(1) Furthermore, an estimated 12% of families with children ages 0-18 years residing in Sonoma County had incomes below the Federal Poverty Level (FPL) and 43% of all residents lived below 300% FPL.(8) In 2015, an estimated 3,100 homeless individuals and 127 homeless families with children resided in Sonoma County.(9,10)

Medi-Cal Beneficiaries and Threshold Languages

California's External Quality Review Organization (EQRO), Behavioral Health Concepts, reports that Sonoma County Mental Health Plan's Medi-Cal numbers of unduplicated eligible Medi-Cal beneficiaries by Race/Ethnicity during calendar year 2015 are as follows:

Table 1 provides detail on beneficiaries served by race/ethnicity.

Table 1—Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity Sonoma

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	33,055	34.8%	1,560	54.0%
Hispanic	39,944	42.0%	662	22.9%
African-American	1,936	2.0%	88	3.0%
Asian/Pacific Islander	8,097	8.5%	88	3.0%
Native American	1,365	1.4%	50	1.7%
Other	10,704	11.3%	441	15.3%
Total	95,100	100%	2,889	100%

**The total is not a direct sum of the averages above it. The averages are calculated separately. The actual counts are suppressed for cells containing n ≤11.*

California's Department of Mental Health Information Notice 11-7 reports Spanish as a threshold language for Sonoma County. The California Department of Mental Health (DMH) defines threshold languages as the annual numeric identification on a county-wide basis and as indicated on the Medi-Cal Eligibility Data System of the Medi-Cal beneficiary population in an identified geographic area, whose primary language is other than English, and for whom information and services shall be provided in their primary language [per California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services, Section 1810.410 (f) (3)].

II. Medi-Cal population service needs (Use CAEQRO data if available).

The county shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

Information contained in the following table was taken from California Mental Health and Substance Use System Needs Assessment Appendices February 2012 and can be reviewed in its entirety at the following link:

http://www.dhcs.ca.gov/provgovpart/Documents/Data%20Appendices%203%201%2012.pdf.

Sonoma County Penetration Rates for SMI Mental Health Services			
SMI Prevalence (1) N / %	Medicaid Utilization (2) N / %	ADP (3) N / %	DMH (4) N / %
22,264 / 5%	2,892 / 13%	NR	3,525 / 16%
Sonoma County Penetration Rates for SED Mental Health Services			
7,471 / 7%	604 / 8%	NR	1,774 / 24%
Sonoma County Penetration Rates for Drug and Alcohol Diagnosis Services			
37,598 / 9%	2,533 / 7%	3,663 / 10%	NA

1. These percentages reflect the percent of the total population of the given county that suffer from SMI/SED/ SUD. The total populations of each county included in the MH/SUD Prevalence source data.
2. These percentages reflect the number of individuals within each county who have an SMI/SED/alcohol or drug diagnoses who utilize Medicaid services.
3. These percentages reflect the number of individuals within each county who have an SMI/SED/alcohol or drug diagnoses who utilize ADP services.
4. These percentages reflect the number of individuals within each county who have an SMI/SED/ alcohol or drug diagnoses who utilize DMH services.

B. Provide and analysis of disparities as identified in the above summary.

According to the most current Community Health Needs Assessment (CHNA), Sonoma County residents and stakeholders perceive the need for an increase in accessible mental health services, including preventative care and screening. It was also noted that stigma remains an issue surrounding mental health and mental health treatment, and may prevent some residents

from seeking care. Socioeconomic and other upstream factors may affect access to care, and it should not be assumed that access issues represent a lack of available services.

Within Sonoma County, attention to mental health has increased in recent years, and was ranked as an issue of high concern in the most recent CHNA. Sonoma Residents have a high risk for suicide, with 12.511 per 100,000 county residents dying as a result of suicide (2013-2015). This number is notably higher than the rate of suicide deaths for California residents, which is 10.312 per 100,000 residents for the same time period. Additionally, an estimated 15.2% (13) of Sonoma County residents have reported experiencing poor mental health, defined as problems with mental health, emotions, nerves, or use of alcohol and drugs. There are distinct differences in this prevalence when looking at various demographic groups.

Age

Mental health challenges vary distinctly by age group. The bullets below provide a summary of available data on mental health challenges for Older Adults, Adults, and Youth in Sonoma County.

Children and Youth

- 19.4% of Sonoma County high school students (2011-2012 and 2012-2013 school years) report having seriously considered suicide in the past year (14)
- 48 youth aged 13-20 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries (15)
- 5 children aged 5-14 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries (16)
- Children aged 5-14 in Sonoma County are hospitalized for mental health issues at a rate of 2.7 per 1,000 (17)
- Youth aged 15-19 in Sonoma County are hospitalized for mental health issues at a rate of 11.6 per 1,000 (18)

Adults

- 19.6% of Sonoma County adults 18-59 report needing help for emotional/mental health problems or use of alcohol or drugs, higher than the statewide average of 16.1% (19)

Older Adults

- 10.5% of older adults in Sonoma County, aged 60 and higher, report needing help for mental health issues, higher than the statewide average of 7.4% (20)

Race/Ethnicity

Sonoma County is less racially and ethnically diverse than the State of California as a whole. The vast majority of Sonoma County residents identify as either white or Hispanic, and available demographic data on other groups remains limited.

- 64.8% of white survey respondents in Sonoma County rate their mental health, which includes stress, depression and problems with emotions, as “very good” or “excellent” (21)

- 44.6% of Hispanic respondents survey respondents rate their mental health, which includes stress, depression and problems with emotions, as "very good" or "excellent" (22)

Housing Status

Homelessness remains a high priority issue for Sonoma County residents. The 2016 Point in Time Homeless Count identified a population of 2,906 individuals experiencing homelessness, 66% of whom were identified as living without shelter. Unsheltered homeless included those individuals living on the street, in encampment areas, in cars, or in abandoned buildings. The remaining 34% lived in either transitional housing or emergency shelters. A number of the individuals counted during the census were surveyed on the spot. Of 594 respondents, 39% reported psychiatric or emotional conditions, and 42% reported drug or alcohol abuse. (23)

Economic Status

While many of Sonoma County's residents are socioeconomically secure, 11.7% of county residents reported annual incomes below Federal Poverty Level in 2015.(24) According to the 2013 Sonoma County Community Health Needs Assessment, "Given the high cost of living in Sonoma County, it is generally accepted that an annual income under 200% of FPL ($21,660 for an individual) is inadequate to meet basic needs for food, clothing, shelter, transportation, health care and other necessities." (25) There appear to be notable disparities in reported mental health between those living with incomes below 200% of the FPL, and those with higher incomes.

- Among respondents living under 200% of FPL, 40.2% report "excellent" or "very good" mental health as compared with 71.2% of those with higher incomes.(26)
- Among those living below 200% of FPL, over 30% report only "fair" or "poor" mental health.(27,24)

Education

There appear to be similar disparities regarding level of education and mental health.

- Among Sonoma County adults with the highest education levels (college graduate or above), 72% report excellent/very good mental health (28)
- 28.6% of those without a high school degree report excellent/very good mental health (29)
- Over 30% of those without a high school degree report fair/poor mental health (30)

The 2016 Sonoma County Community Health Needs Assessment can be found at the following link: http://www.sonomahealthaction.org/content/sites/sonoma/cnha_2016/Sonoma_CHNA_FINAL_Report.pdf.

III. 200% of Poverty (minus Medi-cal) population and service needs

The county shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

The following table is made available by the CA Department of Health Care Services. These tables demonstrate mental health and alcohol and other drug prevalence estimates. These tables are available to all California counties. To review the complete report, follow the following link: http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Children and Youth in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Youth Total	2,553	29,326	8.7
AGE			
00-05	982	11,292	8.7
06-11	839	9,625	8.71
12-17	732	8,409	8.71
GENDER			
Male	1,274	14,524	8.77
Female	1,279	14,902	8.64
ETHNICITY			
White - NH	748	8,570	8.73
African American - NH	63	702	9.04
Asian - NH	92	1,073	8.6
Pacific Islander - NH	6	69	8.83
Native - NH	22	241	9.12
Other - NH	0	0	0
Multi - NH	84	955	8.82
Hispanic	1,537	17,716	8.68

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Adult Total	6,305	76,006	8.71
AGE			
18-20	172	5,374	3.2
21-24	646	9,005	7.17
25-34	1,612	15,730	10.25
35-44	1,437	11,862	12.12
45-54	1,253	10,669	11.75
55-64	707	9,261	7.63
65+	477	14,104	3.38
GENDER			
Male	2,331	34,176	6.82
Female	3,974	41,830	9.5
ETHNICITY			
White - NH	3,869	42,589	9.08
African American - NH	140	1,446	9.66
Asian - NH	100	2,850	3.49
Pacific Islander - NH	7	151	4.47
Native - NH	89	766	11.64
Other - NH	0	0	0
Multi - NH	148	1,690	8.78
Hispanic	1,952	26,515	7.36
MARITAL STATUS			
Married	1,575	26,175	6.02
Sep/Wid/Div	2,594	24,469	10.6
Single	2,153	25,362	8.42
EDUCATION			
Grades 00-11	2,154	26,976	7.98
HS Graduate	3,541	40,124	8.82
College Graduate	610	8,906	

B. Ranking the highest to the lowest rates of estimated illness among racial groups is as follows:

For Children and Youth under 18:

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Youth Population (00-17)	2,553	29,326	8.7
ETHNICITY			
Asian – NH	92	1,073	8.6
Hispanic	1,537	17,716	8.68
White – NH	748	8,570	8.73
Multi – NH	84	955	8.82
Pacific Islander – NH	6	69	8.83
African American - NH	63	702	9.04
Native - NH	22	241	9.12

For Adults 18+:

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Total Adult (18+)	6,305	76,006	8.71
ETHNICITY			
Pacific Islander - NH	7	151	4.47
Asian - NH	100	2,850	3.49
Hispanic	1,952	26,515	7.36
Multi - NH	148	1,690	8.78
White - NH	3,869	42,589	9.08
African American - NH	140	1,446	9.66
Native - NH	89	766	11.64

IV. MHSA Community Services and Supports (CSS) population assessment and service needs.

The county shall include the following in the CCPR:

A. From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

The following data was extracted from our mental health and substance use disorders data systems.

Mental Health Medi-Cal Beneficiary data for client utilization data by race, ethnicity, language, age, and gender and other factors:

By Age	Count of Clients	%age
0-17	1319	37.03%
18-64	2265	59.36%
65+	189	3.61%
Grand Total	3773	100.00%

By Race	Count of Clients	%age
Alaskan Native	1	0.03%
American Indian	74	2.01%
Asian Native	1	0.03%
Black/African-American	202	5.44%
Cambodian	10	0.28%
Chinese	13	0.29%
Filipino	11	0.25%
Guamanian	4	0.11%
Hawaiian	10	0.28%
Japanese	5	0.14%
Korean	7	0.19%
Laotian	14	0.37%
No Entry	364	10.13%
Other Asian	27	0.74%
Other Race	655	17.86%
Samoan	3	0.08%
Vietnamese	5	0.14%
White	2367	61.64%
Grand Total	3773	100.00%

By Language	Count of Clients	%age
Cambodian	1	0.03%
Cantonese	5	0.14%
English	3403	90.05%
Farsi	2	0.06%
French	1	0.03%
Hebrew	2	0.06%
Ilocano	2	0.06%
Japanese	2	0.06%
Lao	6	0.15%
Mandarin	1	0.03%
No Entry	75	2.10%
Other Non-English	20	0.30%
Other Sign Language	1	0.03%
Russian	1	0.01%
Samoan	1	0.03%
Spanish	225	6.23%
Tagalog	1	0.03%
Unknown / Not Reported	23	0.61%
Vietnamese	1	0.03%
Grand Total	3773	100.00%

By Ethnicity	Count of Clients	%age
Cuban	3	0.08%
Mexican/Mexican American	624	17.13%
No Entry	982	26.76%
Not Hispanic	1897	48.86%
Other Hispanic/Latino	125	3.40%
Puerto Rican	8	0.22%
Unknown	134	3.54%
Grand Total	3773	100.00%

Sexual Orientation	Count of Clients	%age
Bisexual	22	0.61%
Declined To State	133	3.13%
Gay (male)	15	0.42%
Heterosexual / Straight	441	11.87%
Lesbian (female)	6	0.15%
No Entry	3136	83.27%
Transgender	11	0.31%
Unsure / Questioning	9	0.25%
Grand Total	3773	100.00%

By Gender	Count of Clients	%age
Female	1768	46.91%
Male	2001	53.00%
Transgender (F to M)	1	0.03%
Transgender (M to F)	1	0.01%
Unknown	2	0.06%
Grand Total	3773	100.00%

Employment	Count of Clients	%age
Competitive job market 20-35 hrs a week	92	2.52%
Competitive job market 35 hrs + a week	54	1.50%
Competitive job market less thn 20 hrs a wk	64	1.72%
Full-time homemaking responsibility	10	0.28%
Job training, full-time	5	0.14%
No Entry	197	5.36%
Not in the labor force	714	17.56%
Part-time school/job training	44	1.18%
Rehabilitative work, 20 to 35 hrs a week	9	0.23%
Rehabilitative work, less 20 hrs a week	9	0.23%
Rehabilitative work,35 hrs or more week	1	0.03%
Resident/Inmate	7	0.20%
Retired	30	0.68%
School, full-time	941	26.39%
Unemployed, actively seeking work	155	4.25%
Unemployed, not actively seeking work	1105	29.19%
Unknown	313	8.10%
Volunteer Work	23	0.46%
Grand Total	3773	100.00%

Substance Use Disorder Medi-Cal Beneficiary data for client utilization data by race, ethnicity, language, age, and gender and other factors:

Race List	Race Count
Alaskan Native	1
Alaskan Native | American Indian	1
Alaskan Native | White	3
American Indian	152
American Indian | Black / African-American	2
American Indian | Black / African-American | White	1

American Indian | Mixed Race	1
American Indian | Other Race	6
American Indian | Other Race | White	2
American Indian | Vietnamese	1
American Indian | White	33
Asian Indian	12
Black / African-American	252
Black / African-American | Mixed Race | White	2
Black / African-American | Other Race	3
Black / African-American | White	8
Cambodian	5
Chinese | White	5
Filipino	4
Filipino | Hawaiian	1
Filipino | White	2
Guamanian	2
Hawaiian	11
Hawaiian | Mixed Race | White	1
Japanese	1
Japanese | White	14
Korean	4
Laotian	9
Mixed Race	176
Mixed Race | Other Race | White	1
Mixed Race | White	10
Other Asian	16
Other Asian | White	1
Other Race	601
Other Race | White	29
Samoan	2
Vietnamese	2
White	3544
Left Blank (incomplete)	4
Total	4925

Language	Language Count
Amharic	1
English	343
Spanish	8
Not Filled Out	4573
Total	4925

Gender	Gender Count
Female	1759
Male	3163
Other	3
Total	4925

Admission Age	Admission Age Count
0 -17	272
18-64	4539
65+	114
Total	4925

Ethnicity	Ethnicity Count
Cuban	2
Mexican / Mexican American	584
Not Hispanic	3971
Other Hispanic / Latino	345
Puerto Rican	20
Left Blank (incomplete)	3
Total	4925

B. Provide an analysis of disparities as identified in the above summary.

The following is a brief overview of Sonoma County's mental health landscape, with data provided for specific groups wherever available.

The following is a brief overview of Sonoma County's mental health landscape, with data provided for specific groups wherever available. For more information follow this link: http://www.sonomahealthaction.org/content/sites/sonoma/cnha_2016/Sonoma_CHNA_FINAL_Report.pdf.

According to the most current Community Health Needs Assessment (CHNA), Sonoma County residents and stakeholders perceive the need for an increase in accessible mental health services, including preventative care and screening. It was also noted that stigma remains an issue surrounding mental health and mental health treatment, and may prevent some residents from seeking care. Socioeconomic and other upstream factors may affect access to care, and it should not be assumed that access issues represent a lack of available services.

Within Sonoma County, attention to mental health has increased in recent years, and was ranked as an issue of high concern in the most recent CHNA. Sonoma Residents have a high risk for suicide, with 12.5 per 100,000 county residents dying as a result of suicide (2013-2015). This number is notably higher than the rate of suicide deaths for California residents, which is 10.3 per 100,000 residents for the same time period. Additionally, an estimated 15.2% of Sonoma County residents have reported experiencing poor mental health, defined as problems with mental health, emotions, nerves, or use of alcohol and drugs. There are distinct differences in this prevalence when looking at various demographic groups.

Age

Mental health challenges vary distinctly by age group. The bullets below provide a summary of available data on mental health challenges for Older Adults, Adults, and Youth in Sonoma County.

Children and Youth

- 19.4% of Sonoma County high school students (2011-2012 and 2012-2013 school years) report having seriously considered suicide in the past year
- 48 youth aged 13-20 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries
- 5 children aged 5-14 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries
- Children aged 5-14 in Sonoma County are hospitalized for mental health issues at a rate of 2.7 per 1,000
- Youth aged 15-19 in Sonoma County are hospitalized for mental health issues at a rate of 11.6 per 1,000

Adults

- 19.6% of Sonoma County adults 18-59 report needing help for emotional/mental health problems or use of alcohol or drugs, higher than the statewide average of 16.1%

Older Adults

- 10.5% of older adults in Sonoma County, aged 60 and higher, report needing help for mental health issues, higher than the statewide average of 7.4%

Race/Ethnicity

Sonoma County is less racially and ethnically diverse than the State of California as a whole. The vast majority of Sonoma County residents identify as either white or Hispanic, and available demographic data on other groups remains limited.

- 64.8% of white survey respondents in Sonoma County rate their mental health, which includes stress, depression and problems with emotions, as “very good” or “excellent”
- 44.6% of Hispanic respondents survey respondents rate their mental health, which

includes stress, depression and problems with emotions, as "very good" or "excellent"

Housing Status

Homelessness remains a high priority issue for Sonoma County residents. The 2016 Point in Time Homeless Count identified a population of 2,906 individuals experiencing homelessness, 66% of whom were identified as living without shelter. Unsheltered homeless included those individuals living on the street, in encampment areas, in cars, or in abandoned buildings. The remaining 34% lived in either transitional housing or emergency shelters. A number of the individuals counted during the census were surveyed on the spot. Of 594 respondents, 39% reported psychiatric or emotional conditions, and 42% reported drug or alcohol abuse.

Economic Status

While many of Sonoma County's residents are socioeconomically secure, 11.7% of county residents reported annual incomes below Federal Poverty Level in 2015. According to the 2013 Sonoma County Community Health Needs Assessment, "Given the high cost of living in Sonoma County, it is generally accepted that an annual income under 200% of FPL ($21,660 for an individual) is inadequate to meet basic needs for food, clothing, shelter, transportation, health care and other necessities." There appear to be notable disparities in reported mental health between those living with incomes below 200% of the FPL, and those with higher incomes.

- Among respondents living under 200% of FPL, 40.2% report "excellent" or "very good" mental health as compared with 71.2% of those with higher incomes.
- Among those living below 200% of FPL, over 30% report only "fair" or "poor" mental health.

Education

There appear to be similar disparities regarding level of education and mental health.

- Among Sonoma County adults with the highest education levels (college graduate or above), 72% report excellent/very good mental health
- 28.6% of those without a high school degree report excellent/very good mental health
- Over 30% of those without a high school degree report fair/poor mental health

V. Prevention and Early Intervention Plan: The process used to identify the PEI priority populations

The county shall include the following in CCPR:

A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:

1. Underserved cultural populations
2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
4. Trauma-exposed
5. Children/you at risk of school failure
6. Children/youth at risk or experiencing juvenile justice involvement

The 2017-2020 Work Plan Summaries for the Integrated Plan for Prevention and Early Intervention (PEI):

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations

Promotion

- California Mental Health Services Authority (CalMHSA)
- Each Mind Matters, Know the Signs, Directing Change

Prevention

- Services targeting children birth to age 5 and their families
- Services targeting school-aged children ages 5 to 18 years
- Campus-based services targeting transition age youth
- Services targeting older adults
- Services targeting communities who experience disparity in access to mental health services
- Consumer/Peer Run Services
- Suicide Prevention

Early Intervention

- Services targeting transition age youth ages 16 to 24 at risk of experiencing first onset of mental illness

B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g. assessment tools or method utilized).

Each of the proposed PEI projects described in the MHSA PEI Plan is the result of a collaborative planning effort between SCBH and stakeholders, including community service providers, medical professionals, consumers, and their family members. All steps throughout the planning process meet the statutory and regulatory requirements for timing, stakeholder participation and representation, approvals and budgets at outlined in CA Welfare and Institutions Code and the California Code of Regulations Title 9 (CCR).

The intent of this section is to provide a brief description of the integrated planning process, as

well as the involvement of community and local stakeholders in reviewing and approving the Integrated Plan and future MHSA-funded projects. The Sonoma County Behavioral Health Division partners with the community to ensure each plan and update is developed with local stakeholders, with meaningful input and involvement on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget.

BHD uses a variety of opportunities and processes to seek stakeholder input to ensure full community participation. BHD continues to use traditional (meetings, forums, etc.) and non-traditional (radio, one-on-one and small group discussion) approaches for engaging the community about the planning process and seeking input from the community about the Update. BHD takes special care to meet with and receive input from historically underserved communities in ways identified as appropriate by these groups and individuals. Some of the strategies employed were to bring together diverse representative stakeholders from the community as an Advisory Committee to play an active role in guiding this local integrated planning process. Stakeholder representatives met once a month between November 2016 and April 2017 and were charged with oversight and direction in our community engagement process.

The MHSA Advisory Committee is comprised of 31 individuals of diverse demographic backgrounds who represent a mix of consumers, service providers, and family members.

Organization/Agency	Stakeholder Representation
Buckelew Programs Sonoma County	Families of adults and seniors with severe mental illness
Burbank Housing	Providers of Services and supportive housing for people with severe mental illness
Community Baptist Church	Unserved and/or underserved populations (African Americans)
Community Development Commission	Providers of Services
Community Housing Sonoma County	Providers of Services and supportive housing for people with severe mental illness
Consumer Relations Program-Goodwill Industries of the Redwood Empire	Adults and seniors with severe mental illness; Unserved and/or underserved populations (geographically isolated communities)
Interlink Self Help Center- Goodwill Industries of the Redwood Empire	Adults and seniors with severe mental illness/substance use disorders
Latino Service Providers	Unserved and/or underserved populations (Latinos)
Mental Health Board	Adults and seniors with severe mental illness; Families of children, adults, seniors with severe mental illness, service providers

Organization/Agency	Stakeholder Representation
NAMI – Sonoma County	Families of children, adults, seniors with severe mental illness
Petaluma People Services	Social Services Agency/Providers of Services; Unserved and/or underserved populations (geographically isolated communities)
Petaluma Police Department	Law Enforcement
Santa Rosa Junior College	Education
Sonoma County Sheriff's Department	Law Enforcement
Veteran Resource Centers of America	Veterans
West County Community Services	Social Services Agency/Provider of Services
West County Health Centers	Health Care Providers
Sonoma County Department of Health Services Staff	
Health Services Department-Behavioral Health Division (BHD)	BHD Director, MHSA Coordinator and Community Mental Health Section Manager, Community Intervention Program Manager, Program Planning and Evaluation Analyst
Health Services Department – Health Policy Planning and Evaluation (HPPE) Division	HPPE Director

The Advisory Committee members also played an active role in the distribution of an MHSA Community Input Survey that collected feedback on current services offered, underserved populations living with mental health challenges, and new ideas for the expansion of services.

The Behavioral Health Division, in coordination with Harder+Company Community Research (H+C), collected stakeholder input on services that enhance and strengthen the existing system of mental health services in Sonoma County. This stakeholder input process was designed to gather feedback to inform the 3-year planning process. The MHSA Integrated Plan Advisory Committee developed outreach plans and distributed a 9-item survey to stakeholders from communities throughout Sonoma County. Outreach plans—developed in coordination with BHD and H+C—were designed to ensure survey distribution to diverse and representative stakeholder groups. In total, 564 surveys were collected between January and March 2017, and analysis was then conducted by H+C.

The Community Input Survey asked respondents to assess the following:

- Perspective on existing services offered through MHSA funding
- Underserved populations living with mental health challenges and their greatest needs (e.g. by ethnicity, age, and special populations – foster youth, transition age youth, veterans, geographically isolated individuals with mental health issues)
- Expanded and enhanced services previously identified that put MHSA principles into practice

The charts below provides an overview of Sonoma County survey respondents:

Figure 1: Percent of Survey Respondents by Age (n=526)

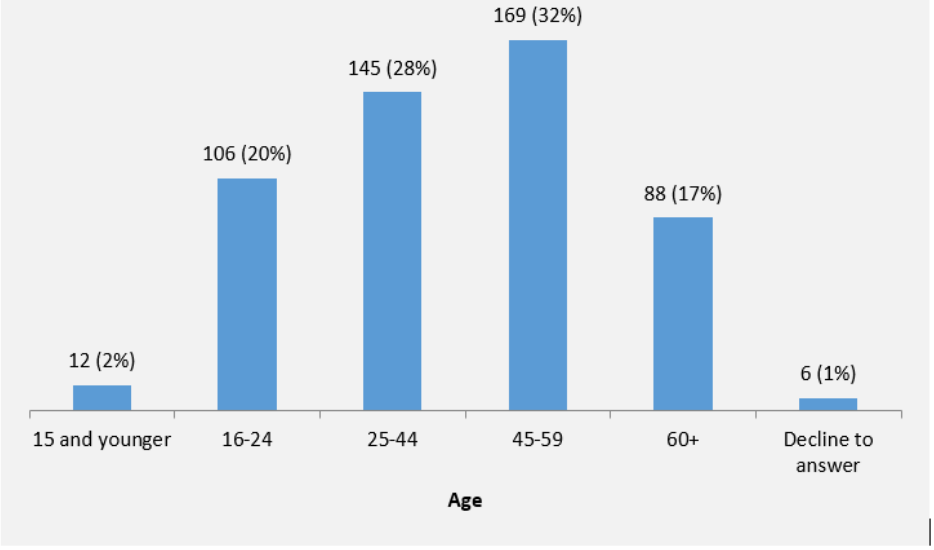


Figure 2: Percent of Survey Respondents by Race/Ethnicity (n=515)

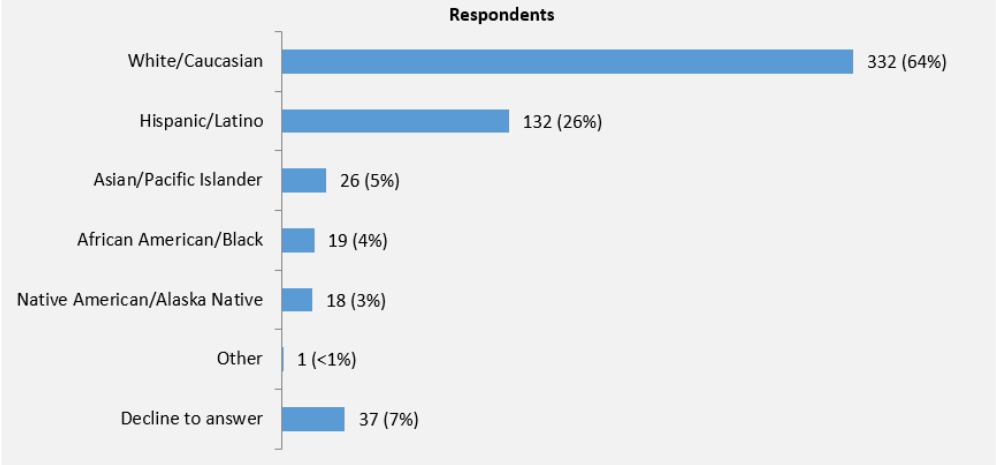


Figure 3: Percent of Survey Respondents by Geographic Area in Sonoma County (n=521)

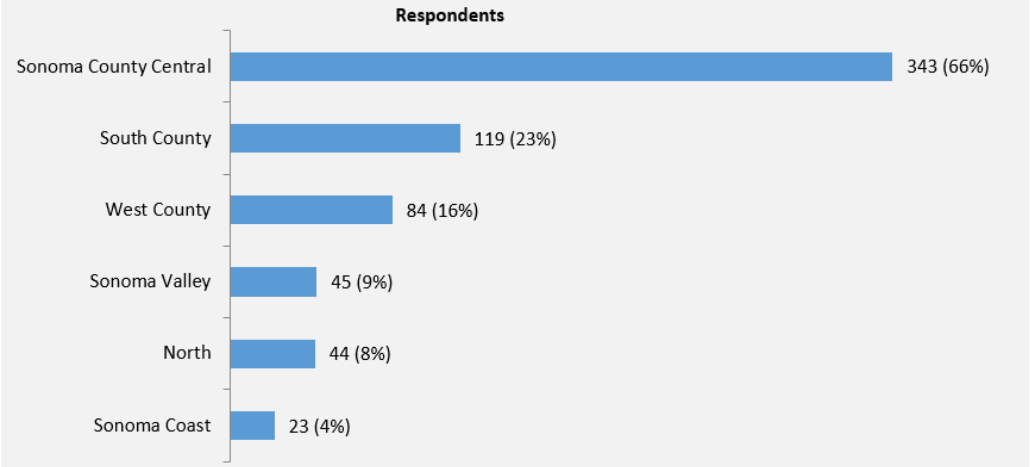
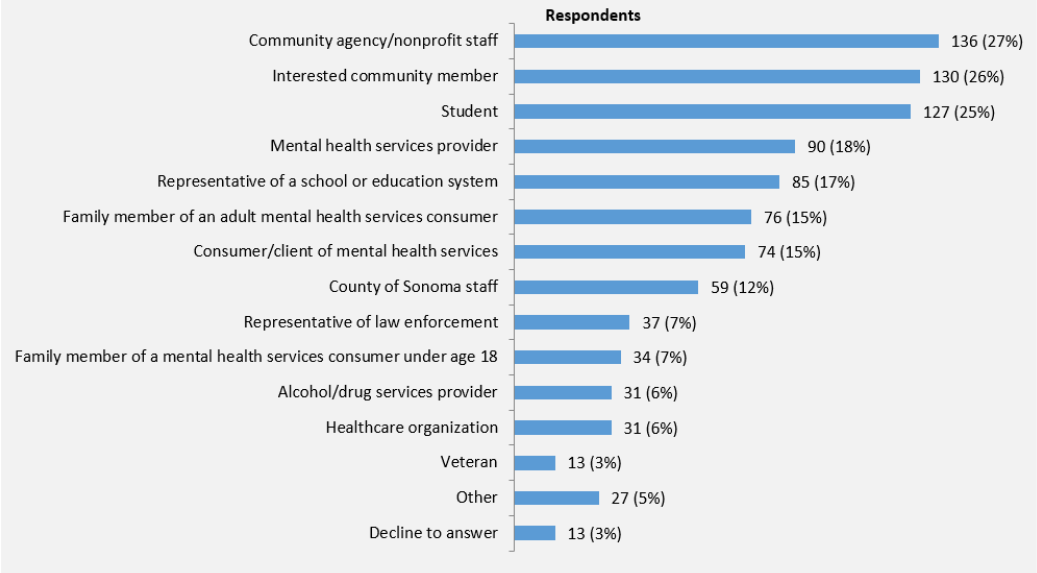


Figure 4: Percent of Survey Respondents by Representative Group (n=508)



BHD's inclusive and ongoing stakeholder engagement process resulted in identifying a priority list of ten enhanced services. The premise for the integrated plan focused on strengthening the existing comprehensive and successful continuum of mental health services that MHSA has anchored in place, and that has transformed the Sonoma County mental health delivery system. Consequently, ten enhanced services were identified that will help put MHSA principles into practice:

- Expand mental health services to additional high schools and/or middle schools
- Expand the Crisis Assessment, Prevention, and Education (CAPE) team in high schools

and middle Schools
- Expand Mobile Support Team (MST) into additional communities
- Expand the Community Intervention Program (CIP) to strengthen homeless outreach
- Continue to hire consumers to be employed by Sonoma County Behavioral Health
- Increase bilingual/bicultural services
- Enhance children's mental health services, including crisis services
- Strengthen support services to family members
- Enhance older adult mental health services
- Support statewide projects such as mental health public education and suicide prevention campaigns

Sonoma County's Integrated Planning process was guided by an Advisory Committee Group comprised of the BHD Director, MHSA Coordinator, and 31 individual stakeholders from various sectors (e.g., law enforcement, consumers, education), with Harder+Company Community Research providing planning and facilitation services. The committee established planning goals to facilitate the plan development, as well as a guiding framework to reinforce the importance of sustaining the changes that have already taken place as a result of MHSA.

For more information about the Integrated Planning Process beginning on page 19 of the *MHSA Planning process for the 2017-2020 Three-Year Integrated Plan & Annual Update for 2015-2016* use the following link: http://www.sonoma-county.org/health/about/pdf/mhsa/2017-2020-MHSA-integrated-plan.pdf.

CRITERION 3
COUNTY MENTAL HEALTH SYSTEM STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. Identified unserved/underserved target populations (with disparities):

The county shall include the following in the CCPR:

- Medi-Cal population
- Community Services and Supports (CSS) Population. Full Service Partnership population
- Workforce, Education, and Training (WET) population. Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations. These populations are county identified from the six PEI priority populations

A. List identified target populations with disparities within each of the above selected (Medi-Cal, CSS, WET, PEI priority populations)

The 2017-2020 Work Plan Summaries for the Integrated Plan (as well as the 2015-2016 Annual Update) are represented within the three MHSA Service Components:

1. Community Services and Supports (CSS)
Provides enhanced mental health services for Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill (SMI) adult populations

Access, Treatment and Recovery Programs

- Full Service Partnerships Outreach and Engagement (to increase access)
- General Systems Development

Workforce, Education and Training (WET) *(falls under the CSS funding component)*

- Consumer/Peer and Family Member Behavioral Health Career Pathways
- Postgraduate Internships
- Bilingual Behavioral Health Career Pathways

2. Prevention and Early Intervention (PEI)
Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations

Promotion

- California Mental Health Services Authority (CalMHSA)
- Each Mind Matters, Know the Signs, Directing Change

Prevention

- Services targeting children birth to age 5 and their families
- Services targeting school-aged children ages 5 to 18 years
- Campus-based services targeting transition age youth
- Services targeting older adults
- Services targeting communities who experience disparity in access to mental health services
- Consumer/Peer Run Services
- Suicide Prevention

Early Intervention

- Services targeting transition age youth ages 16 to 24 at risk of experiencing first onset of mental illness

3. Innovation (INN)
Novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals

- Integrated Health Team (IHT)
- Mobile Support Team (MST)

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, and PEI priority/targeted populations).

Respondents to the above mentioned Community Input Survey identified the following underserved population(s) living with mental health challenges that have Greatest Need.

Survey respondents were asked to identify which underserved population(s) living with mental health challenges have the greatest need for mental health prevention and early intervention services in Sonoma County. The top five underserved populations rated as “greatest need” for all respondents are the following:

1. Individuals with co-occurring substance use disorders (79% of all respondents)
2. Foster youth (76% of all respondents)
3. Geographically isolated individuals with mental health issues (71% of all respondents)
4. Veterans (70% of all respondents)
5. Transition Age Youth – TAY (65% of all respondents)

Disparities in access to mental health services is the most significant disparity for the above identified populations. For the above populations access disparity may be a result of:

- Not knowing where services are available; and/or
- Available services may be inaccessible to the individual seeking services; and/or
- Stigma about seeking mental health treatment; and/or
- Discrimination due to seeking mental health treatment.

III. Identified strategies/objectives/actions/timelines

The county shall include the following in CCPR:

A. List the strategies identified in CSS and PEI plans for reducing disparities identified.

BHD's inclusive and ongoing stakeholder engagement process resulted in identifying a priority list of expanded services considered MOST important to provide in the future. The premise for the integrated plan focused on strengthening the existing comprehensive and successful continuum of mental health services that the MHSA has anchored in place, and that has transformed the Sonoma County mental health delivery system. Consequently, expanded services were identified that will help put MHSA principles into practice:

Expanded Services Considered Most Important to Provide in the Future

Respondents were also asked to rate which expanded services are the most or least important to provide in the future to persons of all ages with mental health challenges. The top five expanded services rated as "very important" are the following:

1. Enhance children's mental health services (61% of all respondents)
2. Expand the Mobile Support Team (MST) (57% of all respondents)
3. Increase bilingual/bicultural services (56% of all respondents)
4. Expand the Crisis Assessment, Prevention, and Education (CAPE) Team (53% of all respondents)
5. Expand mental health services to additional high schools and/or middle schools (51% of all respondents)

Respondents aged 60 and older selected the same list of top five expanded services as the general population. Of survey respondents who identified as consumers and clients of mental health services, the top five expanded services reported as "very important" are the following:

1. Expand the Mobile Support Team (MST) (71% of all consumers and clients of mental health services)
2. Continue to hire consumers to be employed by Sonoma County BHD (70% of all consumers and clients of mental health services)

3. Enhance children's mental health services (66% of all consumers and clients of mental health services)
4. Strengthen support services to family members (59% of all consumers and clients of mental health services)
5. Expand the Community Intervention Program (CIP) (58% of all consumers and clients of mental health services)

B. List the strategies identified for each targeted area noted in Criterion 2 in the following sections:

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Full Service Partnership		
Program Name:	Family Advocacy, Stabilization and Support Team (FASST)		
Total # to be served (annually):	64	**Cost per Client (for FY 17-18):**	$1,949

Description of Program:

Sonoma County Behavioral Health's Family Advocacy, Stabilization and Support Team (FASST) is an intensive enrollee-based Full Service Partnership program for youth (ages 5-18) identified as needing intensive and integrated services, including:

- Enhanced capacity to provide Therapeutic Behavioral Services (TBS)
- Individual and family therapy
- Rehabilitative groups
- Family/parent education
- Intensive Home Based Services (IHBS)
- Intensive Care Coordination (ICC), including close collaboration with Human Services, Probation, and/or Education
- Medication support services
- Linkage to other services, including Substance Use Disorder (SUD) treatment services
- Crisis intervention

Priority Population:

This program serves high-risk SED children who have not responded to traditional levels of service. Youth are prioritized for the program by meeting any of the following risk criteria, along with meeting medical necessity for specialty mental health services:

- At risk of psychiatric hospitalization, or those who have been hospitalized within the past six months
- At risk of congregate care placement
- Involvement with the Juvenile Probation system
- Human Services dependents

Community Partners:
The following community partner provides contracted services under the FASST Program: • Sunny Hills Services

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Full Service Partnership		
Program Name:	Transition Age Youth (TAY) Team		
Total # to be served (annually):	55	**Cost per Client (for FY 17-18):**	$6,988

Description of Program:

Sonoma County Behavioral Health's Transition Age Youth (TAY) Full Service Partnership program provides services for youth ages 18 to 25 and their families to respond to the many challenges encountered as the youth with mental illness moves toward greater self-sufficiency.

The TAY program is an intensive integrated service team program for Transition Age Youth (18-25) providing mental health services, intensive case management, housing and employment support services, and independent living skills.

- Case Management Specialist for Transition Age Youth needing referrals to Linkage follow-up
- Permanent supportive housing services, staffed by community partners, that include:
  - Independent living apartments (including master lease and collaboration with a 14 unit building)
  - Psychiatric Rehabilitation Approach (PRA)
  - Assistance w/medication management, medication adherence, and crisis response
- Transition Age Youth County-Wide Team provides:
  - Structured Clinical Interview for DSM-5 Disorders (SCID-5-CV)
  - Outreach
  - Case Management
  - Employment opportunities
  - Socialization activities
- Peer support and mentoring
- Linkage and referral to substance abuse treatment for TAY living with co-occurring disorders

Priority Population:

Transition Age Youth 18-25 with SED/SMI, aging out of children's Mental Health services, and are at risk of homelessness, hospitalization, or incarceration; aging out of Child Welfare; who are leaving placement; or are experiencing First Episode Psychosis (FEP).

Community Partners:
The following community partners provide contracted services under the Transition Age Youth program: • Buckelew supportive employment • Buckelew Transition Age Youth housing • Social Advocates for Youth – Transition Age Youth housing • VOICES – Peer support and mentoring • NAMI Sonoma County – Family support and advocacy

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Full Service Partnership		
Program Name:	Forensic Assertive Community Treatment (FACT) Team		
Total # to be served (annually):	50	**Cost per Client (for FY 17-18):**	$18,237

Description of Program:
Sonoma County Behavioral Health's Forensic Assertive Community Treatment (FACT) team is a Full Service Partnership that serves adult offenders with Serious Mental Illness (SMI) by providing a community-based treatment team as an alternative to incarceration. The FACT team serves offenders with SMI coming directly from the jail through a Mental Health Court (MHC). • FACT program components include multiple case management sessions each week, monthly psychiatric consultation, medication management, group counseling, referral to substance abuse treatment, scheduled and random urinalysis testing, and money management. The FACT team is on call 24/7 in order to support non-hospital crisis intervention, and FACT clients are required to be in attendance at the program's offices several days each week. • The MHC acts as both a diagnostic and disposition tool for the Sonoma County Criminal Justice System. The MHC is a collaboration between the Sheriff's Office, Probation, the District Attorney, Public Defender, the Superior Court, and the Santa Rosa Police Department. The Court addresses the complex needs of mentally ill offenders through community-based sentencing and closely supervised probation. All FACT clients are on probation and monitored by the MHC and the on-site probation officer, who participates in all FACT treatment planning meetings. FACT team members participate in MHC decision processes, regularly providing testimony on clients' participation in FACT program activities. • Peer mentoring/support is included and helps in forming a gradual close relationship based on mutual trust. The goal is empowerment and awareness of positive options.

Priority Population:
Non-violent mentally ill offenders booked into Sonoma County Jail; priority to those with two or more previous incarcerations and/or failures to appear; inmates with no previous incarceration eligible if Mental Health determines them to be at risk for recidivism; severe mental health diagnosis; repeated contact with the mental health system; Sonoma County residents; willing to participate; exclusions for history of arrests for serious violent offenses.
Community Partners:
The following community partner provides contracted services under the FACT Program: • Buckelew FACT housing

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Full Service Partnership		
Program Name:	Integrated Recovery Team (IRT)		
Total # to be served (annually):	165	**Cost per Client (for FY 17-18):**	$11,648

Description of Program:
Sonoma County Behavioral Health's Integrated Recovery Team (IRT) is a Full Service Partnership that serves adults with co-occurring mental illness and substance use disorders and provides an integrated treatment that addresses mental and substance use conditions at the same time to ensure overall better health outcomes. IRT utilizes an Integrated Dual Diagnosis Treatment (IDDT) approach for adults with co-occurring disorders (mental illness and substance use). Treatment focuses on the stages of change, and both a harm reduction approach and motivational interviewing is utilized. Pharmacological treatment, case management, self-help groups run by peers, family education, and aftercare services are provided. Program has a high staff-to-client ratio and ability to respond 24/7. Housing and employment services are part of the array of supports offered by this program.
Priority Population:
IRT provides services to adults with serious mental illness and co-occurring alcohol and other drug problems, who currently do not receive comprehensive services.

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Full Service Partnership		
Program Name:	Older Adult Intensive Team (OAIT)		
Total # to be served (annually):	35	**Cost per Client (for FY 17-18):**	$19,155

Description of Program:

Sonoma County Behavioral Health's Older Adult Intensive Team (OAIT) is a Full Service Partnership that provides intensive, integrated services for older adults with serious mental illness, coupled with more complex medical conditions requiring close coordination between the mental health and primary or specialty medical providers.

- The team provides intensive case management, helping clients to access needed primary and specialty medical care and to ensure ongoing coordination between the clients' mental health and physical health providers.
- The program includes supported housing services designed to assist the older adult clients in living as independently as possible. The support services include medication management and adherence support, coordination with health care providers, and coordination with family or friends who are acting as caregivers for the clients.
- The program leverages existing MHSA funding peer support services.
- The program provides support to the family and friends of clients who are acting as caregivers.

Priority Population:

OAIT provides services to older adults with serious mental illness who also have complicating medical conditions.

Community Partners:

The following community partners provide contracted services under the OAIT program:

- Council on Aging
- West County Community Services
- Jewish Family and Children's Services

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Outreach & Engagement		
Program Name:	Access Team		
Total # to be served (annually):	550	**Cost per Client (for FY 17-18):**	$4,065

Description of Program:
The Access Team improves access to mental health treatment for residents of Sonoma County who are Medi-Cal beneficiaries and meet the criteria for treatment by the Mental Health Plan. The Access Team provides information and referral to all Sonoma County residents who are not Medi-Cal beneficiaries who may need mental health services. The Access Team provides brief stabilization services (medication management and education, housing options, employment resources, benefits counseling, and therapy) for Medi-Cal beneficiaries. Individuals seeking services are able to quickly receive a mental health screening, and, when needed, assessment and specialty mental health treatment planning. The Access Team determines appropriate levels of care for individuals and creates linkage to the network of mental health services available throughout Sonoma County. The Access Team also serves as a gateway for any person needing mental health services regardless of coverage and provides links to other community resources for any caller.
Priority Population:
Sonoma County Medi-Cal beneficiaries

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Outreach & Engagement		
Program Name:	Community Intervention Program (CIP)		
Total # to be served (annually):	3,750	**Cost per Client (for FY 17-18):**	$665

Description of Program:
Collaboration between mental health professionals and community and primary care providers is likely to be more effective when the clinicians are co-located and the location is familiar and non-stigmatizing for clients. (Evolving Models of Behavioral Health Integration in Primary Care – Milbank Memorial Fund) Co-located with community services providers and primary care, the Community Intervention Program (CIP) provides mental health services on-site with participating agencies: • Enhanced mental health services at homeless shelters in Santa Rosa, Petaluma and Guerneville. Enhanced outreach capacity. • Enhanced capacity to provide culturally based on-site mental health services at key ethnic-specific health centers serving Latinos, Asians, Native Americans, and African Americans. Services include: o Psychiatry o Crisis intervention o Peer support o Outreach o Improved cultural competency training capacity

- Enhanced capacity within the community to provide urgent response. Mental Health partners with law enforcement in Santa Rosa, Guerneville and Petaluma; includes Peer Outreach positions
- Enhanced capacity to provide mental health services within a collaborative service approach at AODS and substance use provider facilities

Priority Population:

The priority population is individuals with serious mental illness who are homeless and/or have co-occurring alcohol and other drug problems, and those underserved ethnic minority community members (Latinos, Asians, Native Americans, and African Americans) who are accessing services at the community health centers, but are not receiving mental health services; veterans; people at high risk for mental deterioration; people who are geographically isolated, members of the LGBTQ+ community.

Community Partners:

The following community partners provide contracted services under the Community Intervention Program:

- Alliance Medical Center, Inc. (FQHC)
- Drug Abuse Alternatives Center (DAAC)
- Sonoma County Human Services Department – JOB LINK
- Sonoma County Indian Health Center (SCIHP)
- Santa Rosa Community Health Centers (SRCHC)
- Petaluma People Services Center (PPSC) – Mary Isaak Center for the Homeless
- West County Health Centers, dba Russian River Health Center (FQHC)

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Outreach & Engagement		
Program Name:	Community Mental Health Centers (CMHCs) – (part of CIP)		
Total # to be served (annually):	150	**Cost per Client (for FY 17-18):**	$15,378

Description of Program:

Regionally based Community Mental Health Centers (CMHCs) provide intensive community services and supports enhancing mental health services throughout Sonoma County. The CMHCs are primarily aimed at providing access for underserved populations, including providing culturally and linguistically appropriate services to locally underserved racially and ethnically diverse communities, and homeless individuals with mental illness, in four regionally-based areas of Sonoma County.

The service teams are linked to the larger adult systems of care but focus on providing services and supports in the smaller communities where they are located. These Sonoma County communities include Guerneville, Cloverdale, Petaluma, and Sonoma.

Additionally, these CMHCs have enhanced capacity within each community to provide field-based crisis response, not previously available in any of Sonoma County Behavioral Health Services programs. Services are available through partnerships between each CMHC and community-based providers and law enforcement agencies in each city. CMHC behavioral health staff work in collaboration with the local Federally Qualified Health Centers (FQHCs).

Priority Population:

CMHCs provide services to adults with serious mental illness who are living in areas that are geographically isolated. CMHCs also provide access to services to people who are homeless and/or have co-occurring alcohol and other drug problems, and those underserved ethnic minority community members (Latinos, Asians, Native Americans, and African Americans).

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Family Driven Services		
Total # to be served (annually):	1,700	**Cost per Client (for FY 17-18):**	$259

Description of Program:

Sonoma County Behavioral Health provides MHSA funds to support family member programs throughout Sonoma County. Family Driven Services are services that provide support for family members and loved ones of people who have mental disorders.

Supports include Family to Family classes; family support groups in and around Sonoma County, including Petaluma, Santa Rosa, Sebastopol, and Sonoma; Warmline; outreach and individual family support specifically for Latino families; health education, support, and advocacy, service navigation to assist family members and loved ones in accessing services for themselves as well as their loved one.

Priority Population:

Family members and loved ones of people with mental disorders.

Community Partners:

The following community partners provides contracted family driven services:

- National Alliance for Mental Illness (NAMI) – Sonoma County
- Buckelew Programs – Family Services Coordination

Community Services and Supports **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Consumer/Peer Driven/Operated Services		
Total # to be served (annually):	1,200	**Cost per Client (for FY 17-18):**	$949

Description of Program:

Sonoma County utilizes MHSA funds to develop and support consumer/peer driven programs, including wellness centers for consumers/peers facing the challenges of living with a serious mental illness, and a consumer relations program.

These consumer-driven wellness programs are managed and staffed by people with lived mental health experience; they are a centralized meeting place for consumers. Recovery principles are integrated throughout the centers' programming, which include

- Employment programs
- Recreational and socialization opportunities
- Consumer-operated business
- Art studio and store
- Horticulture and community garden
- Peer/self advocacy program

The Consumer Relations Program provides opportunities for mental health consumers to have direct participation in developing appropriate mental health services.

Priority Population:

The priority population is transition age young adults, adults, and older adults with serious mental illness. Persons of all genders, sexual orientation, races, and ethnicities are served.

Community Partners:

The following community partners provides contracted consumer driven services:

- Goodwill Industries of the Redwood Empire
  - Interlink Self Help Center
  - Wellness and Advocacy Center
  - Petaluma Peer Recovery Program
  - Consumer Relations Program
- West County Community Services
  - Russian River Empowerment Center

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Services to children ages birth to 5 years and their families
Program Name:	Early Childhood Mental Health (0-5) Collaborative

Total # to be served (annually):	3,500	**Cost per Client (for FY 17-18):**	$132

Description of Program:

Sonoma County utilizes MHSA funds for the Early Childhood Mental Health Collaborative to provide screening, services, and support through a continuum of care for children ages birth to 5 years and their families, as well as pregnant and newly parenting mothers at risk for perinatal mood disorder. This collaborative is a partnership with First 5 Sonoma County.

The Ages and Stages Questionnaire (ASQ 3) and the ASQ Social-Emotional (ASQ-SE) are used by primary care providers and other child care providers to screen children for developmental and social emotional issues.

Families are provided with support via Triple P – Positive Parenting Program. Triple P is an evidence-based parenting program that gives parents simple and practical strategies to help them confidently manage their children's behavior, prevents problems developing, and builds strong, healthy relationships.

Priority Population:

Children ages birth to 5 years old and their families

Community Partners:

The following community partners provide contracted services under the Early Childhood Mental Health Collaborative program:

- Early Learning Institute
- Petaluma People Services Center
- Child Parent Institute

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	School based services to youth ages 5-18		
Program Name:	Student Assistance Program (Project SUCCESS Plus)		
Total # to be served (annually):	2,000	**Cost per Client (for FY 17-18):**	$217

Description of Program:

Project SUCCESS is an evidence-based student assistance program (NREPP) which is also listed as Tier 1 for the Sonoma County Upstream Investments Initiative Portfolio. Enhancements were added to the model with developer-input and became Project SUCCESS+ (Project SUCCESS Plus or

PS+). Project SUCCESS Plus addresses a broader spectrum of behavioral health issues, with increased emphasis on mental health issues. This is accomplished through the delivery of culturally appropriate prevention education, early identification, screening strategies, individual/group level interventions and referrals for needed services. The PS+ Model includes the following core components:

- Prevention Education Series (PES)
- Screening
- Individual and group level interventions
- Family engagement and parent programs
- Referral and resources
- School staff development
- School-wide awareness and outreach
- Community coalitions

Priority Population:

Youth ages 13-18

Community Partners:

Six school districts:

- Petaluma, Rohnert Park-Cotati, Windsor, Cloverdale, Healdsburg, and West Sonoma County

Community-based organizations that are service delivery partners:

- Currently, this includes West County Community Services, Support Our Students (SOS) and National Alliance for Mental Illness.

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	School based services to youth ages 5-18		
Program Name:	Santa Rosa Community Health Centers PEI program		
Total # to be served (annually):	750	**Cost per Client (for FY 17-18):**	$124

Description of Program:

Santa Rosa Community Health Centers (SRCHC) Prevention & Early Intervention (PEI) program specifically targets Latino children and youth ages 5 to 18 and their families. The goals of the program are to:

- Ensure earlier access to mental health services, to lower the incidence of mental illness and suicide, to enhance wellness and resilience, and to reduce stigma and discrimination in Sonoma County for children from early childhood through the school years

- Engage children, youth and their parents prior to the development of serious mental illness or serious emotional disturbances and to alleviate the need for additional mental health; or to transition the individual to extended mental health treatment
- Build capacity for mental health prevention and early intervention services at sites where people go for other daily activities (e.g., health providers, education facilities, and community organizations)

The contracted services are:

- Triple P interventions for Latino teens, parents and children at a school-based Health Center, the Lombardi Health Center, and/or the school site
- Community outreach to promote early intervention and reduce stigma
- Student assistance programs
- Screening for identification of behavioral health issues early enough to reduce escalation
- Brief therapy
- Patient support groups
- Parent Child Interaction Therapy (PCIT) and early intervention services to parents of children in preschool or elementary school

Priority Population:
Youth ages 5-18

Community Partners:
The following community partner provides contracted services: • Santa Rosa Community Health Centers

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Campus-based services targeting Transition Age Youth		
Program Name:	Santa Rosa Junior College PEERS Coalition		
Total # to be served (annually):	1,200	**Cost per Client (for FY 17-18):**	$167

Description of Program:
Community colleges serve a high proportion of students who are at greater risk of suicide than traditional students, including older students and commuter students. Also at high risk are international students, LGBTQ students, and veterans. (California Community College Task Force, 2012). Sonoma County utilizes MHSA funds to support prevention activities at Santa Rosa Junior College. Activities include:

- Organize student outreach
- Utilize on-campus social media interventions to decrease stigma and increase access
- Plan and organize events and fairs
- Mental health training and education for students, faculty, and other staff
- Mental health student screening and assessment
- Engage students to be peer leaders
- Activities to reduce depression and prevent suicide
- Activities to decrease stigma and discrimination

Priority Population:

Transition age youth ages 18-25

Community Partners:

The following community partner provides contracted services:

- Santa Rosa Junior College – PEERS (People Empowering Each Other to Realize Success) Coalition

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Services targeting older adults		
Program Name:	Older Adult Collaborative		
Total # to be served (annually):	4,000	**Cost per Client (for FY 17-18):**	$61

Description of Program:

Sonoma County Behavioral Health utilizes MHSA funds to support the Older Adult Collaborative to provide multi-layered prevention services to reduce depression and suicide among older adults countywide. This is accomplished through outreach to seniors; screening of seniors identified to be at risk for isolation, depression, and/or suicide; counseling through an expansion of an intern program; and referral of seniors to Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors).

Priority Population:

Older adults

Community Partners:

The following community partners provide contracted services:

- Sonoma County Human Services Department – Adult and Aging Division

- West County Community Services
- Jewish Family and Children's Services
- Petaluma People Services Center
- Council on Aging

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Services targeting communities that experience disparity in access to mental health services		
Program Name:	Reducing Disparities		
Total # to be served (annually):	14,500	**Cost per Client (for FY 17-18):**	$43

Description of Program:

Targeted outreach is essential and necessary to provide effective mental health prevention into communities who have historically been denied easy access to care. People who are from disparate communities are best served by trusted messengers from their community. These communities include rural residents, communities of color, including tribal areas, LGBTQ+ community members. (National Association of State Mental Health Program Directors, January 2014).

Sonoma County MHSA funds programs that provide culturally appropriate, community defined activities, programs, and services that reach underserved populations in Sonoma County.

Services are providers include faith based organizations, organizations in rural and isolated areas in Sonoma County, trusted youth organizations, health providers, and providers that focus on specific populations.

Priority Population:

Sonoma County residents who live in geographically isolated communities; ethnically and culturally diverse residents (specifically communities of color); LGBTQ+ residents

Community Partners:

The following community partner provides contracted services:

- Latino Service Providers
- Action Network
- Community Baptist Collaborative
- Alexander Valley Healthcare
- Positive Images
- Sonoma County Indian Health Project

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Suicide Prevention Services		
Program Name:	North Bay Suicide Prevention Hotline of Sonoma County		
Total # to be served (annually):	4,500	**Cost per Client (for FY 17-18):**	$36

Description of Program:

The North Bay Suicide Prevention (NBSP) Hotline of Sonoma County, a program of Buckelew Programs, provides 24/7 suicide prevention and crisis telephone counseling. Buckelew's highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. Counselors help to enhance the callers' coping and problem-solving skills, giving people in crisis alternatives to violence to themselves or others and relief from the profound isolation of crisis, loss and/or chronic mental illness. Accredited by the American Association of Suicidology, Buckelew's Hotline has been part of the National Suicide Prevention Lifeline (a toll free national number that connects callers to their closest certified crisis line) since its inception in 2005. The NBSP Hotline responds to calls from Sonoma County made to the National Lifeline.

Because no fees are charged for the phone service and help is accessible 24/7, the Hotline is available for people of all ages and socio-economic levels. Factors that tend to inhibit individuals from seeking other sources of help, like cost and transportation, do not impede people from seeking support from the Hotline. The Hotline serves as a vital link to essential mental health support services and referrals throughout Sonoma County.

Priority Population:

Sonoma County residents who are experiencing a mental health crisis

Community Partners:

The following community partner provides contracted services:

- Buckelew Programs

Prevention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Consumer/Peer Driven Services		
Program Name:	Peer Warmline Connection of Sonoma County		
Total # to be served (annually):	1,600	**Cost per Client (for FY 17-18):**	$34

Description of Program:

The Peer Warmline Connection of Sonoma County will provide compassionate and culturally appropriate services to peers with lived mental health experiences. The Warmline program is a peer-run program that is administratively controlled and operated by mental health consumers and emphasizes self-help as its operational approach. The focus of the Warmline program is to provide a telephone connection for people with mental health challenges who are isolated in their homes, feel the need to speak with another consumer about a variety of issues related to their mental health, and/or are requesting information about a county resource in or out of the mental health system. The Warmline provides individuals with the opportunity to talk through their situations, vent their feelings, or make a connection that reduces their feelings of isolation.

Priority Population:

The priority population is transition age young adults, adults, and older adults with serious mental illness. Persons of all genders, sexual orientation, races and ethnicities are served.

Community Partners:

The following community partner provides contracted services:

- Goodwill Industries of the Redwood Empire

Early Intervention **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Services targeting transition age youth at risk of or experiencing first onset of mental illness		
Program Name:	Crisis Assessment, Prevention, and Education (CAPE) Team		
Total # to be served (annually):	500	**Cost per Client (for FY 17-18):**	$1,699

Description of Program:

The Crisis Assessment, Prevention, and Education (CAPE) Team aims to prevent the occurrence and severity of mental health problems for transition age youth. The CAPE Team is staffed by Sonoma County Behavioral Health licensed and license-eligible mental health clinicians. Services are located in Sonoma County high schools and Santa Rosa Junior College.

The CAPE Team provides:

- **Mobile Response** in schools by licensed mental health clinicians with youth who may be experiencing a mental health crisis.
- **Screening and Assessment** of at-risk youth in high schools and colleges.

- **Training and Education** for students, selected teachers, faculty, parents, counselors and law enforcement personnel to increase awareness and ability to recognize the warning signs of suicide and psychiatric illness.
- **Peer-Based and Family Services**, including increasing awareness, education and training, counseling, and support groups for at-risk youth and their families.
- **Integration and Partnership** with existing school and community resources, including school resource officers, district crisis intervention teams, student and other youth organizations, health centers, counseling programs, and family supports

Priority Population:
Transition age youth (ages 16 to 25) who may be experiencing first onset of mental illness

Community Partners:
The following community partner provides contracted services: • National Alliance for Mental Illness (NAMI) – Sonoma County

Innovation **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Innovation		
Program Name:	Mobile Support Team (MST)		
Total # to be served (annually):	600	**Cost per Client (for FY 17-18):**	$2,012

Description of Program:
The need for better collaboration between law enforcement and mental health providers has long been reported. Research shows that an integrated mobile response to behavioral health crises has numerous positive outcomes for the person in crisis, law enforcement officers, and the community (Kisely, S. 2010). Sonoma County Behavioral Health MHSA funds crisis services to respond with law enforcement to support Sonoma County residents who are having a behavioral health crisis. Sonoma County's Mobile Support Team (MST) adapts crisis response team models that rely on the involvement of licensed clinicians and integrates trained consumers and family members into the team who engage in a number of bridge-building activities with consumers and family members involved in a crisis.

Consumers and family members are a key resource to not only mitigate further crisis, but also to create relationships with law enforcement officers in order to reduce stigma and increase awareness.

Priority Population:

Sonoma County residents who are experiencing a behavioral health crisis that requires law enforcement intervention

Community Partners:

The following community partners provide contracted services:

- National Alliance for Mental Illness (NAMI) – Sonoma County
- Goodwill Industries of the Redwood Empire – Peer Support Program
- Support Our Students (SOS)

Innovation **FY 2017-2020 WORK PLAN SUMMARY**

Service Category:	Innovation		
Program Name:	Integrated Health Team (IHT)		
Total # to be served (annually):	400	**Cost per Client (for FY 17-18):**	$2,042

Description of Program:

Well referenced studies show that individuals with serious mental illness treated by the public mental health system die 25 years earlier than the general population, due in part to untreated physical health conditions. Their life expectancy is 51 years on average, compared with 76 years for the general population. People living with serious mental illness are 3.4 times more likely to die of heart disease, 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments (C. Colton, based on 1997-2000 data.).

Sonoma County MHSA dollars fund the Integrated Health Team to bring physical health services to a mental health services site. The integrated, collaborative model brings primary care, mental health, and other necessary social supports to one setting, and allows Sonoma County to implement a clinical model which has demonstrated success. The Sonoma County primary care and mental health integration model provides a unique opportunity to capture lessons learned during implementation.

The Integrated Health Team:

- Provides integrated primary care co-located at a Behavioral Health community program in order to meet the physical health care needs of mental health clients
- Out-stations Family Nurse Practitioner from Santa Rosa Community Health Center

- Integrates people with lived experience on team to support care navigation

Priority Population:

People who are diagnosed with a severe and persistent mental disorder, many of whom have co-occurring physical health issues

Community Partners:

The following community partner provides contracted services:

- Santa Rosa Community Health Centers – SAMHSA Bridges program

IV. Additional strategies/objectives/actions/timelines and lessons learned.

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, and PEI. N/A

V. Planning and monitoring of identified strategies/objectives/timeliness to reduce mental health disparities

The county shall include the following in the CCPR:

A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.)

Programs and strategies identified in Section III and IV above have been implemented.

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timeliness on reducing disparities identified strategies.

Sonoma County Behavioral Health Division continues to implement Netsmart's Avatar system to serve as an electronic health record for individuals who are receiving specialty mental health services. This electronic health record will allow the capturing of data as to monitor effectiveness of services provided to the Medi-Cal beneficiary. Also, the Division's Mental Health Services Act (MHSA) is in the process establishing the data collection electronically for MHSA contractors by way of Sonoma Web Infrastructure for Treatment Services (SWITS) performance management reporting data system. SWITS aims to provide the department, selected programs, and MHSA PEI contractors with the ability to collect data that will be used to analyze the effectiveness of programs. The Proposed SWITS Implementation and Annual Outcomes Report Process for Prevention and Early Intervention programs, outreach teams and MHSA Contractors Four Year Implementation Plan. The goal is to develop a system of data collection and evaluation to provide annual reports to DHCS and the MHSOAC that are in alignment with statewide

requirements to improve the accuracy of MHSA data collection and provide performance-based outcomes reports. The timeline is as follows:

FY 15-16 & FY 16-17: SWITS Implementation with County outreach teams (5) & PEI contractors (7 scopes of work)

FY 17-18: *SWITS Implementation with remaining County outreach teams (2)*
SWITS Implementation with remaining PEI contractors (11 scopes of work)
SWITS Implementation with CSS contractors (17 scopes of work)

FY 18-19 & 19-20: MHSA Annual Outcomes Report Process and Implementation with PEI and CSS contractors (35)

FY 16-17 Projected Plan:

- PEI contractors will continue to report demographic data and outcomes/narrative data via MHSA quarterly reports until they are live in SWITS.
- Once live in SWITS, PEI contractors will report demographic data via SWITS. They will continue to report outcomes/narrative data via MHSA quarterly reports (narrative section/version).
- It is projected that PEI contractors will report outcomes/narrative data via an Annual Outcomes Report by FY 20-21.

FY 17-18 Projected Plan:

- CSS contractors will start and complete the SWITS conversion process and database training
- CSS contractors will continue to report demographic data and outcomes/narrative data via MHSA quarterly reports until they are live in SWITS.
- Once live in SWITS, CSS contractors will report demographic data via SWITS. They will continue to report outcomes/narrative data via MHSA quarterly reports (narrative section/version).
- It is projected that CSS contractors will report outcomes/narrative data via an Annual Outcomes Report by FY 20-21.

FY 18-19 & 19-20 Projected Plan:

- All MHSA contractors (PEI & CSS) will be in SWITS by the start of FY 18-19
- SC-BHD will provide technical assistance to all MHSA contractors, clustered by initiative (i.e. Reducing Disparities), at MHSA Learning Circles to develop evaluation plans and revise scopes of work
- SC-BHD will create an MHSA Annual Outcomes Report template for all MHSA contractors to replace the quarterly report (for outcomes/narrative data)
- It is projected that all MHSA contractors will be using the MHSA Annual Outcomes Report by FY 20-21

C. Identify county technical assistance needs. N/A

CRITERION 4
COUNTY MENTAL HEALTH SYSTEM
CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE INTEGRATION OF THE COMMITTEE WITH THE COUNTY MENTAL HEALTH SYSTEM

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

The county shall include the following in the CCPR:

A. Brief Description of the Cultural Competence Committee or similar group (organizational structure, frequency of meetings, function, and role.)

The Mission of the Division of Behavioral Health Services Quality Management Program is to monitor and promote improvement of clinical services by reviewing, monitoring and reporting on clinical data gathered as measured against prevailing standards of the industry, State and Federal guidelines, and evidence-based practices. Through this review and reporting, the Quality Management Program staff recommends implementing certain methods, techniques and best practices to assure the highest clinical practices are adopted and the reimbursement process is accurate. The Sonoma County Cultural Responsiveness Committee sits in the Quality Management Program.

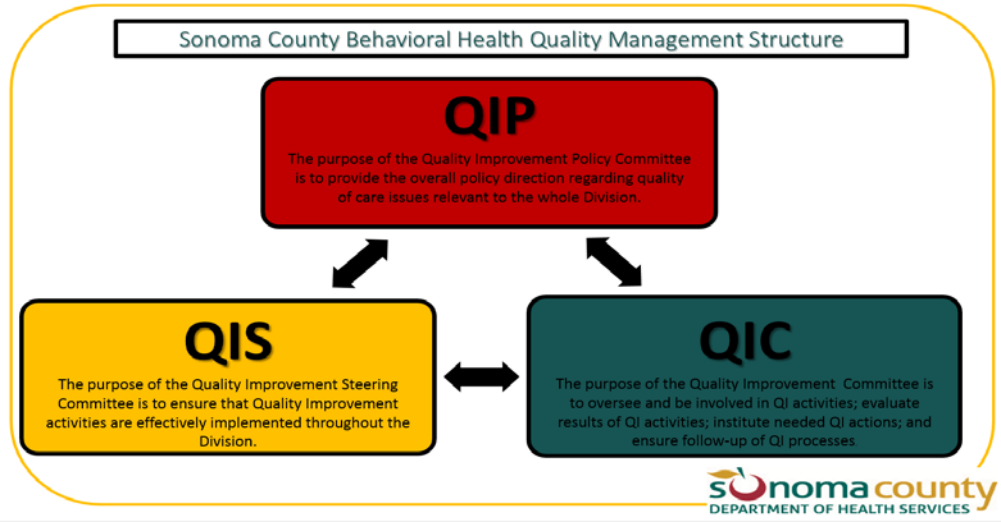
The Quality Management Program is designed to assure all beneficiaries and stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness can recover.

The Division's practitioners, providers, consumers and family members and other stakeholders are active participants in the planning, design, and execution of the Quality Management Program. Stakeholder participate in QM committees described below, or through various sub-committees or through particular quality management activities.

As such, the Quality Management Program is divided into committees: The Quality Improvement Policy Committee, the Quality Improvement Steering Committee, and the Quality Improvement Committee. Each Committee has specific responsibilities, activities and oversight. Each Committee reports to or provides direction to the other committees. Each Committee tracks their activities so that projects, activities and policy issues are followed through to the end of the issue at question.

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community including county management level, line staff, clients, family members from ethnic, racial, and cultural groups, providers, community partners, contractors and other members as necessary.
C. Organizational Chart:

The diagram below illustrates the interactions between and among all of the Quality Management Committees. QMP is multi-layered with 3 committees: Quality Improvement Policy Committee (QIP), Quality Improvement Steering Committee (QIS), and Quality Improvement Committee (QIC). Each Committee has specific responsibilities, activities and oversight. The Cultural Responsiveness Committee has a subcommittee on each Committee. Each Committee gives and receives input and feedback to every other Committee.

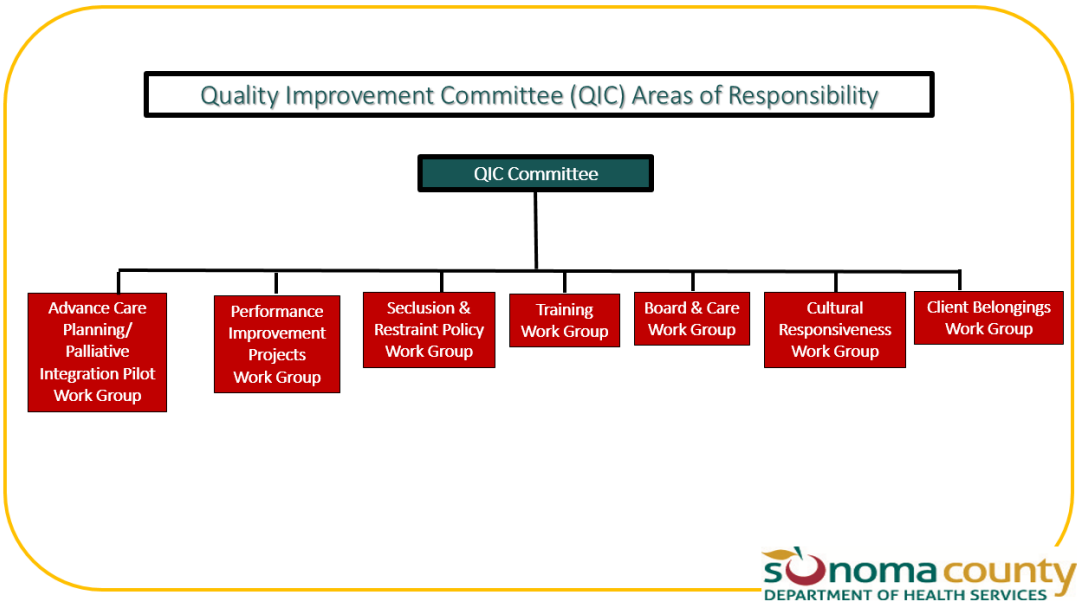


The charts below illustrate the areas of responsibilities of each Quality Improvement Committee and where the Cultural Responsiveness Committee fits into the overall Sonoma County Quality Improvement Program.

Quality Improvement Committee (QIC)

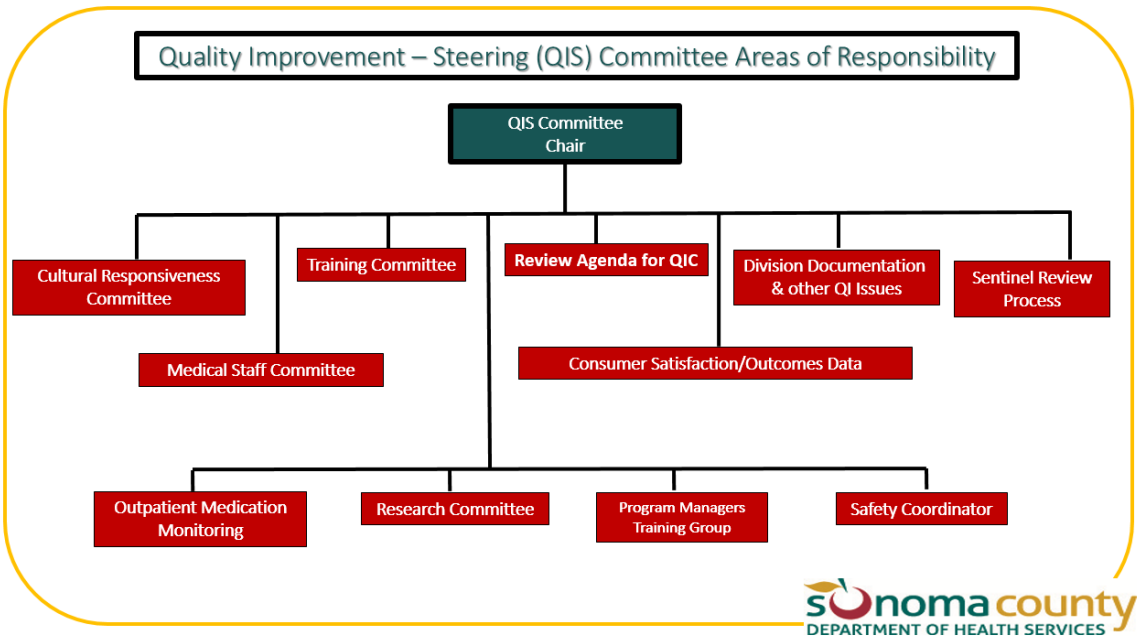
The purpose of QIC is to oversee and be involved in quality improvement activities including policy issues; review and evaluate results of QI activities; institute needed QI actions; and follow-up of QI processes. Furthermore, QIC is one venue for community participation of the MHSA Community Planning Process. QIC members identify community issue related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of MHSA; analyze the mental health needs in the community; and identify and re-evaluate priorities and strategies to meet those mental health needs.

The areas of responsibility for the QIC are to; monitor and review consumer relations/outcomes; develop and review an annual QI work plan; review data and work plan activities; and monitor performance improvement projects.



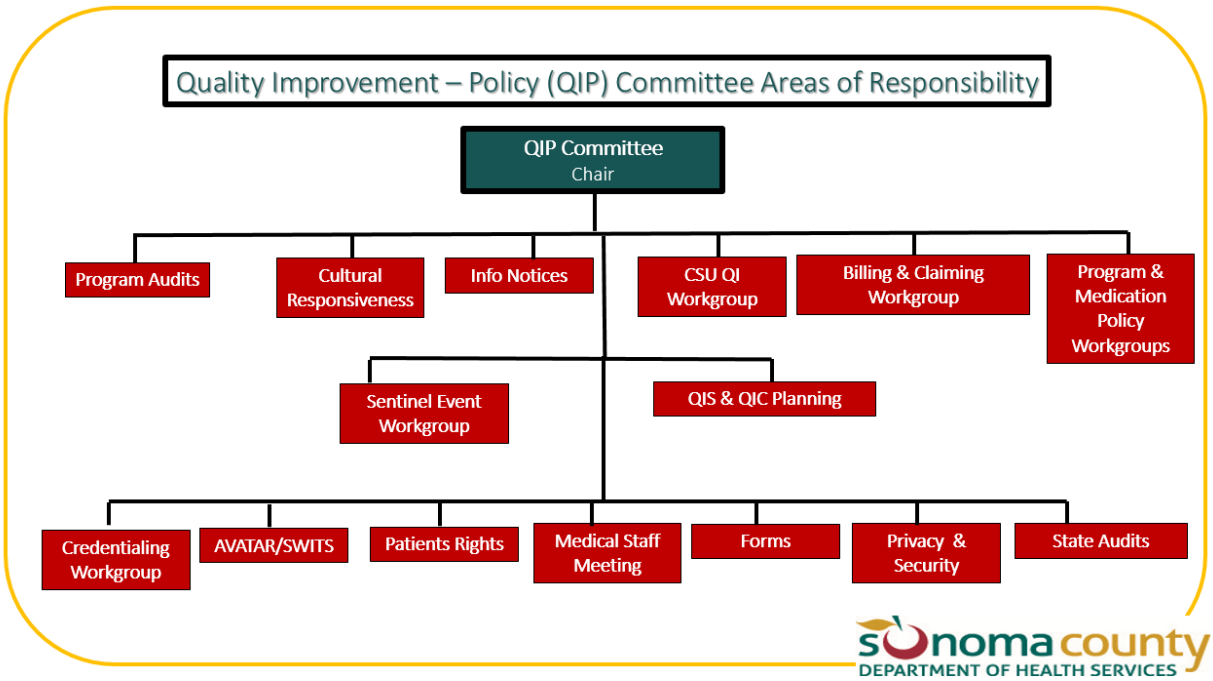
Quality Improvement Steering Committee (QIS)

The purpose of QIS is to ensure that quality improvement activities are effectively implemented throughout the Division. QIS functions as the central organizing body for the Division. QIS receives direction from and provides recommendations to QIP, gives guidance to and receives information and recommendations from QIC. QIS is responsible for reviewing and making recommendations regarding Consumer Satisfaction/Outcomes data and reviewing general documentation and other quality improvement issues as the need arises.



Quality Improvement Policy Committee (QIP) The purpose of QIP is to provide the overall policy direction regarding quality of care issues relevant to the whole Division. While each committee communicates and informs all other committees, QIP gives overall direction to the other Committees to analyze, review and make recommendations regarding issues raised in the course of reviewing training, quality improvement or compliance activities.

QIP establishes, reviews and approves recommended policies, training issues, form versions, provider credentialing issues, and policy issues related to the Division including quality Improvement activities. QIP sets policy regarding issues raised in compliance/utilization reviews, including under and over-utilization and reviews beneficiary grievances, appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review, as well as access and service authorizations.



D. Committee membership roster listing member affiliation if any.

QIC membership includes the following stakeholders:

- SCBH Senior Manager(s)
- Behavioral Health providers including clinical practitioners and contractors
- Mental Health and DMC-ODS Plan beneficiaries who have accessed specialty health services
- Family members and/or significant persons (parents, spouses, relatives, legal representatives) of beneficiaries who have accessed specialty mental health or specialty substance use disorders services
- Educators and/or representatives of education

- Other individuals with lived experience in mental health and substance use disorders
- Healthcare and social service providers
- Law Enforcement and/or representatives of law enforcement
- Other interested stakeholders that represent the interest of individuals with serious mental illness

Below is a member list for QIC during FY 16/17:

QUALITY IMPROVEMENT COMMITTEE (QIC) **Agenda**

March 22, 2017 (4th Wed of Month)
3:30 to 5:00 P.M.
Norton, West Wing Conference Room 3322 Chanate Rd

Members:

- Aiken, George
- Barney, Helene
- Beck, Sonia
- Black, Nitzy
- Breckenridge, Amy
- Boyd, Steven
- Calhoun, Gene
- Darrow, Rhonda (Recorder)
- Ehsan, Asghar
- Farley, Mark
- Faulstich, Amy
- Gaylowski, Will
- Holmes, Donnell
- Kanclerowicz, Kelly
- Kelson, Sean
- Klohe, Erika (Co-Chair)
- Kozart, Michael
- Ladrech, Melissa
- Lobb, Alison
- McColley, Sid (Co-Chair)
- McDavid, Rachael/Lisa Kubiak
- Meyler, Stephanie
- (Ferrand)-Mitchell, Laurie
- Morehouse,Jennifer/Williams,Mike
- Noah, Cammie
- Petersen, Lauren
- Rankin, Carol (QI Liaison)
- Roberge, Kate
- Ryan, Shannon
- Rylaarsdam, A.J.
- Sedney, Vivian
- Seiberlich-Wheeler, Jon
- Smith, Kathy
- Standen, Susan
- Tedesco, Paul / Drum, David
- Wheelwright, Wendy
- Winer, Tamara

II. The Cultural Competency Committee or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competency Committee's activities including the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;

The Cultural Competency Committee develops a plan as a committee and submits that plan to the Quality Improvement Policy Committee. The Committee prioritizes areas of focus each year.

2. Provides reports to Quality Assurance/Quality Improvement Program in the county;

As demonstrated in the above charts, each Committee of the Quality Management Program has a Cultural Competency sub-committee who receives reports, submits reports, or participates in the development of reports to the entire Quality Management Committee

3. Participates in overall planning and implementation of services at the county;

Because Cultural Competency is imbedded in the Quality Management Program, the participation of the Cultural Competency Committee drives all planning and implementation of county services.

4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;

The structure of a Section Manager serving as the CC/ESM that reports directly to the Mental Health Director ensures recommendations are directly transmitted to the executive level of the organization including the Mental Health Director.

5. Participates in and reviews county MHSA planning process;

The steps for reviewing and approving Sonoma County's MHSA Plan are outlined in the Welfare and Institutions Code Section (WIC) § 5847 that states that county mental health programs shall prepare and submit a Plan and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC § 5848 states the mental health board shall conduct a public hearing on the draft three-year program and expenditure plan at the close of the 30-day comment period. These are instructions for the MHSA 2017-2020 Three-Year Integrated Plan & Annual Update for FY 2015-16. These instructions are based on WIC and the California Code of Regulations Title 9 (CCR) in effect at the time these instructions were released.

6. Participates in and reviews county MHSA stakeholder process;

The MHSA Advisory Committee is comprised of individuals of diverse demographic backgrounds who represent a fairly even mix of consumers, service providers, and family members. Additional stakeholder representation information about the composition of the Advisory Committee is summarized in the chart below. Member of the QIC and the Cultural Competency Committee are included in the stakeholder process (see stakeholders with a Δ)

Organization/Agency	Stakeholder Representation
Consumer Relations Program Δ Wellness and Advocacy Center Δ Interlink Self Help Center Δ Petaluma Peer Recovery ProjectΔ	Adults and seniors with severe mental illness; Unserved and/or underserved populations (geographically isolated communities)
Sonoma County Office of Education Santa Rosa Junior College Δ	Education
Veterans Resource Centers of America	Veterans
NAMI – Sonoma County Δ	Families of children, adults, seniors with severe mental

	illness
Sonoma County Indian Health Project Δ Community Baptist ChurchΔ Latino Service Providers Δ West County Community Services	Unserved and/or underserved ethnic and cultural populations and geographically isolated populations
Buckelew Programs – Sonoma CountyΔ Petaluma People Services Center	Social Service Agency/Provider of Services
Sonoma County Sheriff's Department Santa Rosa Police Department Petaluma Police Department	Law Enforcement
First 5 Sonoma County Early Learning Institute Child Parent Institute VOICESΔ	Families of Children and Foster Youth
West County Health Services Sonoma County Indian Health Project	Health Care Organization
Burbank Housing Community Housing Sonoma	Housing Advocates and Organizations

7. Participates in and reviews county MHSA plans for all MHSA components;

The Sonoma County Behavioral Health Division partners with the community to ensure each plan and update is developed with local stakeholders with meaningful input and involvement on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget.

Not only does BHD have a formal Advisory Committee, BHD uses any opportunity or processes to seek stakeholder input to ensure full community participation. BHD continues to use traditional (meetings, forums, etc.) and non-traditional (radio, one-on-one and small group discussion) approaches for engaging the community about the planning process and seeking input from the community about the Update. BHD takes special care to meet with and receive input from historically underserved communities in ways identified as appropriate by these groups and individuals.

Meeting Name	Stakeholder Group
Monthly Alcohol and Drug Advisory Group	Substance Use Disorders
Monthly MHP Director/Consumer Managers Meeting	Peers/Consumers
Monthly Mental Health Board Meeting	Mental Health Stakeholders
Bi-Monthly Petaluma Health Action Chapter: Behavioral Health sub-committee Meeting	Healthcare/Mental Health/Social Services/Veterans/ Peers and Family Members
Sonoma County PEI Reducing Disparities Project meetings	Cultural Populations
Quarterly North Bay Workforce Education, and Training Meeting	All Stakeholders

Monthly Committee for Healthcare Improvement	Healthcare Providers
Monthly Project SUCCESS + Partners Meeting	Education
Monthly CA Department of Rehab – Co Op meeting	Workforce Development
Monthly Quality Improvement Committee Meeting	Mental Health Community Stakeholders
Quarterly Early Childhood Collaborative Partners meeting	Families with children ages birth to 5 years
Monthly Guerneville Health Action Chapter	West County Stakeholders
Monthly Foster Child Collaboration Meeting	Foster Youth Stakeholders
Monthly Peer Workforce Planning Meeting	Consumer Workforce Stakeholders

Relevant updates to key representative stakeholders with specific populations or services focus:

- Mobile Support Team Operations Committees
- Greater Bay Area Collaborative
- Redwood Community Health Coalition & Partner Health Care Centers– West County Health Services; Santa Rosa Community Health Centers; Alliance Medical Centers, Sonoma Valley Community Health Center
- Human Services Division – Child Welfare

Informal stakeholder meetings individually or in groups with mental health consumers and faith-based advocacy groups representatives from specific diverse ethnic and cultural communities.

The BHD Director and MHSA Coordinator regularly partner with the following organizations to provide MHSA updates on current initiates and programs, allowing for opportunities to participate in the community planning process where applicable. These organizations also provide consistent feedback on MHSA guidelines, policies and quality improvement activities.

Mental Health Consumers
- Russian River Empowerment Center
- Interlink Self Help Center
- Wellness and Advocacy Center

Family Members and loved ones of consumers of mental health services
- NAMI - Sonoma County
- Buckelew Programs

Providers of Service & Social Services Agencies
- Latino Service Providers
- Community Baptist Church
- Human Services Department
- Action Network
- Goodwill Industries
- Social Advocates for Youth
- Positive Images

Health Care Organizations
- St. Joseph's Healthcare Systems
- Kaiser Permanente
- Alexander Valley Health Center
- Sonoma County Indian Health Project
- Redwood Community Health Coalition
- Partnership HealthPlan CA

Veterans
- Veterans Administration
- VetConnect

Education
- Sonoma County Office of Education
- Santa Rosa Junior College
- City of Santa Rosa School District
- West County Union High School District

Families & Children
- Early Learning Institute
- First 5 Sonoma County
- Child Parent Institute
- VOICES

Law Enforcement
- Sonoma County Sheriff's Department
- Santa Rosa Police Department
- Petaluma Police Department
- Cloverdale Police Department

Older Adult/Seniors
- Council on Aging
- Community & Family Services Agency
- Jewish Family & Children's Services

Substance Use Disorders Providers
- Drug Abuse Alternatives Center
- California Human Development

Housing Providers
- Burbank Housing
- Community Housing Sonoma

8. Participates in and reviews client develop programs (wellness, recovery, and peer support programs);

See above

9. Participates in revised CCPR (2010) development.

Participants in revised CCPR (2010)		
Susan Castillo	Cruz Lopez	Amy Howard
Melissa Ladrech	Carol Rankin	

B. Provide evidence the Cultural Competence Committee participates in the above review process.

The Cultural Competency Plan was reviewed at the Quality Improvement Steering Committee on 4/12/17.

C. Annual Report of the Cultural Competency Committee's activities including:

1. Detailed discussion of the goals and objectives of the committee;
2. Review and recommends to county programs and services;
3. Goals of cultural competency plans;

Cultural Responsiveness Committee
2016- 2017 FY Goals

I – Increase outreach to the Latinx Community as evidenced by:

a) **Goal: Increase the number of Latinx receiving mental health outreach services by 5% from previous year** = FY 15/16 = 338 in FY 16/17=180. GOAL NOT MET

b) **Goal: Provide mental health screening to 50% Latinx seen during outreach activities =** 35% of the Latinos that received Outreach/Screening ANSAs were Latino – GOAL NOT MET

c) **Goal: Increase by 5% of Latinx receiving mental health treatment in community health centers from previous year.** FY 15/16 = 207 in FY 16/17 = 231. Increase of 12% - GOAL MET

Strategies	Status
1. Develop partnerships with faith-based organizations serving the Latinx Community	Completed: Collaborate in Health and Wellness Fairs • Health & Wellness Fair – Resurrection Parrish Santa Rosa 10/2/16 • Feria de Salud – 10/9/16 St. John's de Baptist Catholic Church – Healdsburg

	• Health & Wellness Fair – The Year of the Farm Worker – Our Lady of Guadalupe Church - Windsor Provide Triple P – Positive Parenting Program • Three – Triple P Positive Parenting groups were provided at Resurrection Parrish in Santa Rosa
2. Engage and collaborate with organizations serving Latinxs	2. Completed • La Luz – outstation staff 1 day per week • Concilio at La Luz – attend monthly meetings • Fund Latino Service Providers to engage, collaborate, and exchange valuation information to increase awareness of available resources, access programs and services – particularly mental health programs and services; enhance interagency communication, and promote professional development Triple P – Positive Parenting provide in schools with high Latinx enrollment • Sassarini Elementary School – AVANCE Program Sonoma • El Verano Elementary School – El Verano • Sheppard Accelerated Elementary School – Roseland Public School – Santa Rosa
3. Participate in at least 6 fairs per year, targeting the Latinx population.	3. Completed: • La Tortilla Factory Annual Health & Wellness Fair 8/6/16 • Fiesta de Independencia 9/18/16 • Health & Wellness Fair – Resurrection Parrish 10/2/16 • Feria de Salud – 10/9/16 • Mi Future Esta En Health Care 1/27/17 • Roseland Cinco de Mayo Annual Festival 5/5/17
4. Complete 6 mental health screening per month during home visits targeting the Latinx population to determine mental health needs and refer to appropriate level of care, as needed	4. During FY 16/17 an average of 4.75 mental health screenings were administered during home visits that target Latinx. These screenings (Outreach ANSAs and CANs) are scored by the Program Manager to determine level of care need including referrals to the MHP or MCP

II – Assess the cultural competence of SCBH staff every five years and provide training in areas of weakness	
Strategies	**Status**
1. Complete staff cultural competency reassessments: a. Clinical Staff with Cultural CBMC b. Management c. Clerical 2. Participate in Training of Trainers program sponsored by CIBHS for the CBMCS training	1. Completed: see summary below 4:2:C:5 for summary of the Behavioral Health Staff Cultural Competency Re-Assessment 2. Awaiting acceptance into Training of Trainers co-hort
III - Provide Cultural Competence Training and measure outcomes	
Strategies	**Status**
1. Assess reasons the cultural section of the CANS/ANSA is currently under-utilized by staff. 1.2 Develop strategies to increase the use of the Acculturation section of the CANS/ANSA to increase usage. 1.3 Implement training for the use of the Acculturation section of the CANS/ANSA	1. Completed: Each treatment team participated in a meeting to provide feedback on the Acculturation Section of the ANSA. Summary findings are discussed at Quality Improvement Steering Committee. 1.2 In Process: The Cultural Responsiveness Coordinator has engaged a graduate-level MSW intern to shepherd this process. 1.3 Not Completed
2. Provide Cultural Awareness Workshops for BH staff 4 times per year	2. Completed: • Conversations on Gangs and the Justice System - 7/27/16 • Serving Veteran's Through Partnership – 9/22/16 • Mental Health Recover: Guiding Principles and Provider Support 1/26/17 • HIV/AIDS and the Impact on Mental Health 3/23/17 • Human Trafficking: What is it? And how do we work with those affected? – 5/25/17
IV – Improve Data Collecting process for all outreach activities and programs	
Strategies	**Status**

Standardize & Implement outreach data collection 1.1 Implement database to analyze data collected on Latinxs through outreach efforts 1.2 Analyze data to determine how many Medi-Cal beneficiaries are seen through outreach activities and types of referrals made.	1.1 Completed – SWITS database has been developed for outreach staff to enter demographic and activity level data 1.2 In process
V – Improve Interpreting Services and staff's ability to use the language line	
Strategies	**Status**
1.Biannual skill building and training and consultation to clerical staff working as interpreters	Completed: • During FY 16/17 the Cultural Competency Coordinator provided 2 trainings for clerical support staff: 2/2/17; 5/11/17; 9/12/17 The MHP is in contact with the National Latino Behavioral Health Association to provide a more robust interpreter training for staff.
2.Quarterly Test Calls to Access and Crisis Stabilization Unit	Completed: • Goal 2.12 of Section 2: Service Accessibility of the FY 16/17 MHP Quality Improvement Work Plan indicates 95% of clients who call the 24-hour toll free number received services in the language they request during business hours and after hours. After-hours calls are directed to OPTUM.
VI – Ensure that our services are culturally & linguistically responsive	
Strategies	**Status**
1. To ensure that Sonoma County Behavioral Health staff matches the population demographics of Sonoma County.	1. In process: The MHP is making every effort to ensure the MHP staff matches, if not exceeds, the demographics of Sonoma County. • Goal 1.7 of Section 1: Service Delivery Capacity: FY 16/17 MHP Quality Improvement Work Plan is to increase the percent of SCBH staff filled FTE who speak Spanish by 5% from FTE 40.55 (42 staff) in FY15-16 to FTE 42.58 in FY16-17.

2. Participate in activities that support the development of a workforce pipeline for Latinx high school students	This goal was not met in this fiscal year. The MHP has lost a large portion of its bilingual Spanish speaking staff to other health care organizations that provide mental health services due to better wages provided. In order to assist with this, the MHP has contracted with Latino Service Providers to provide technical support to the County of Sonoma Behavioral Health Division to develop a web based clearinghouse for recruitment of Bilingual /Bicultural Behavioral Health workforce in Sonoma County. LSP is also assisting to coordinate and sponsor a job fair to recruit bilingual/bicultural clinicians.
	2. Completed: • As mentioned below (4:2: C: 5), the MHP WET Coordinator participates with LSP and the SRJC to sponsor the Mi Futuro en Health Care Symposium. • The MHP Cultural Competency Coordinator provides mentorship through SRJC's Health Occupations Preparation and Education Program (HOPE)
Yearly review of monolingual charts	• Goal 1.10 of Section 1: Service Delivery Capacity: FY 16/17 MHP Quality Improvement Work Plan indicates that the goal of Documentation in 95% of charts audited of monolingual clients in county-run programs and in contractors' programs shows that all services were conducted in the client's primary language was partially met.

4. Human resource report; N/A

5. County organizational assessment;

Below summarizes the highlights of the 2017 Sonoma County Behavioral Health Division Cultural Responsiveness Survey Report.

In accordance with the Cultural Competency Plan, a division-wide Cultural Responsiveness Survey is conducted every three years to assess cultural awareness, knowledge, and training

needs of the SCBH staff. The results of this survey then inform elements of the Workforce Education and Training Plan.

The surveys were administered and collected in June 2017. Three survey types were administered to address differing scopes of work. They survey types are as follows:

SCBH Cultural Competency Assessment Tool	California Brief Multicultural Competence Scale (CBMCS)	SCBH Administrative Staff Cultural Assessment Tool

• Management Staff:
  • Section Managers
  • Program Managers
  • Analysts
	• Clinical Staff:
	  • Specialists
	  • Clinicians
	  • Direct-Service Staff
		• Administrative Staff:
		  • Administrative Aides
		  • Senior Office Assistants
		  • Clerical Staff

Survey Response Rate

75.6% Response (324 Surveys distributed; 245 Surveys returned)

- 42 Admin Support Responses
- 174 Clinical Responses
- 29 Manager Responses

Survey Summary

Administrative Support Staff

SCBH Administrative/Clerical staff report feeling most comfortable in the area of communication with people who are different from them, particularly in displaying an open, non-fearful attitude toward said differences. They report feeling comfortable seeking support from supervisors for cultural issues. Administrative/Clerical staff know what to do when someone comes to the front desk who speaks a different language. They report having access to written notices in multiple languages for interpreter services.

SCBH Administrative/Clerical staff report feeling least comfortable with phone interpretive services. Some of these responses may be due to the survey questions referencing the old Language (People) Line rather than the current CTS Language Line. Staff report concern about the timeliness of interpretive services when the need is immediate. Additionally, a significant portion of Administrative/Clerical staff report needing support/training on how to make non-English appointment reminders.

In sum, SCBH Administrative/Clerical staff communicate comfortably cross-culturally, utilize supervision support, and respond effectively to in-person client interpretation needs. They

would benefit from training around phone interpretive services and non-English appointment reminders. They identified an issue with the timeliness of urgent interpretive needs. Lastly, they indicated several questions with limited relevance for their job focus, suggesting the need for survey revision of those questions.

Clinical Staff

SCBH Clinical Staff report their highest strengths in the area of Cultural Sensitivity, particularly in the use of their communication skills. They are aware of how their own values and institutional barriers affect their clients. SCBH Clinical Staff also scored high in the area of Cultural Awareness, particularly relating to awareness of dominant culture privilege. They report high self-awareness of their own cultural background, experiences, and reactions. In terms of specific client populations, SCBH Clinical Staff report their highest degree of comfort in assessing the mental health needs of women and persons from very poor socioeconomic backgrounds.

SCBH Clinical Staff report their highest need for development in the area of Cultural Knowledge, specifically relating to identifying culturally relevant assessment tools, critiquing multicultural research, and discussing differences within/among ethnic groups. Additional areas for development include knowledge of acculturation models and ability to discuss research regarding mental health issues in culturally diverse populations. Of note were the number of hand-written comments in this section of the survey, stating that these questions were not applicable to the respondent's current work. In terms of specific client populations, SCBH Clinical Staff report highest need for training in assessing the mental health needs of LGBTQ-identified individuals.

In sum, SCBH Clinical Staff show highly effective communication skills and self-awareness of personal values and institutional barriers which affect their clients. They could benefit from further development of skills regarding the critique and application of research and assessment tools in diverse populations; however, there is some question as to the relevance of this domain. As to specific populations, SCBH Clinical staff are highly comfortable assessing the mental health needs of women and persons from poor socioeconomic backgrounds. They could benefit from training in assessing the needs of LGBTQ-identified individuals.

Management Staff

SCBH Management staff report highest confidence in the Consumer Grievance process, the working relationships with CBOs, and the cultural sensitivity of the reception area staff. Of note, the Community Outreach and Engagement efforts of the division received the highest marks of all the domains, specifically for creating strong ties to community partners and building knowledge of the community served.

SCBH Management staff report greatest concern about our work environment reflecting diverse populations served, involving diverse groups in the decision-making process at all levels of staffing, and providing training on the impact of immigration issues. The lowest-scoring domains are as follows: Education & Training; Governance, Systems, Policy Development; Human

Resources & Development. Specific training is requested in the areas of immigration, supervision of multicultural workforce, and assessing cultural proficiency in the performance evaluation process. Additionally, the single largest factor in the suggestions for improvement category was Training Requests, particularly in the areas of cultural differences, assessment, awareness, specific populations, interpreters, and cultural skills.

As to HR and Systems Level, the results were largely mixed, with greatest concern expressed around hiring/retaining diverse staffing and involving diverse staff at all levels of decision-making. Of note is a fairly low score in the domain of Service Delivery on the specific item of incorporating practices and treatment modalities from the diverse populations served.

Several items scored a high incidence of the "Don't Know" response, indicating a need for more information in these areas. The largest gap in knowledge appears to be in the Human Resources & Development domain, specifically in what types of culturally diverse media a position might be advertised. Additionally, there is an unknown in how the organization handles cultural conflicts between staff. Other unknowns center around interpreters, hands-on coaching, and explicit contractual agreements to serve specific sub-groups.

In sum, SCBH Management staff are confident in the Community Outreach and Engagement efforts of the division. They rely upon strong relationships with community partners and express appreciation for the cultural skills of the reception-area staff. SCBH Management staff wish to be more inclusive of a multi-cultural perspective in the decision-making process at all levels. They request specific training regarding immigration issues and supervision of cultural conflicts. Lastly, there appears to be a knowledge gap around Human Resource Development as well as interpreter training and hands-on coaching opportunities for staff.

6. Training plans;

The following chart depicts the training content areas indicated by the survey results, and which levels of staffing reported the training needs.

Training Content Area	Admin/Clerical	Clinical	Management
Interpreters	How and when to use the Interpretation Services		Training of interpreters in Behavioral Health terms and skills
	Timeliness of services		
Immigration		Acculturation models	Impact and issues of immigration
Cultural Differences			Managing a culturally diverse workforce

		Understanding differences within cultures	Engagement of culturally diverse clients
			Cultural awareness
Assessment		Assessment of cultural needs/issues	Utilizing Acculturation section of CANS/ANSA
			Assessing cultural proficiency in performance evaluations
Specific Populations		LGBTQ client needs	Family members
			Developmentally disabled clients
			Older adults

7. Other county activities, as necessary. N/A

CRITERION 5
COUNTY MENTAL HEALTH SYSTEM
CULTURALLY COMPETENT TRAINING ACTIVITIES

I. The County system shall require all staff and stakeholders to receive annual cultural competency training.

The county shall include the following in the CCPR:

A. The county shall develop a three year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required cultural competency training. This number shall be unduplicated.

TOTAL FTE 16/17
331

2. Steps the county will take to provide required cultural competency training to 100% of their staff over a three year period.

Staff are required to sign in to mandatory trainings. Mandatory trainings are recorded. For those staff who do not sign in, the managers are responsible for ensuring that those that missed the training view the video. The procedure is outlined for staff to make up these trainings if the staff did not attend.

3. How cultural competence has been embedded into all trainings.

All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation.

II. Annual cultural competency trainings

The county shall include the following in the CCPR:

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder by function (If available, include if they are clients and or family members)

1. Administration/Management;
2. Direct Services, Counties
3. Direct Services, Contractors

4. Support Services
5. Community Members/General Public;
6. Community Event;
7. Interpreters; and
8. Mental Health Board and Commissioners
9. Community-based Organizations/Agency Board of Directors

B. Annual cultural competence training topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness;
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Mental Health Interpreter Training
7. Training staff in the use of mental health interpreters
8. Training in the use of Interpreters in the Mental Health setting.

Training Calendar FY 16/17:

Training Date	Description of Training	Presenter	Number of Attendees	Training Event (Topics # from list 5.III.B above)	Attendance by Function (Function # from list 5.II. A above)
July 6	5150 Training	Michael Kozart, MD SCBH Medical Director Tamara Winer, LCSW SCBH Patients' Rights Advocate	11	2,4,5	2
July 6	Outreach & Engagement Services	Susan Castillo, MSW, CHC SCBH Melissa Ladrech, LMFT	88	4	1,2,3,4,5
July 11	Master Clinical Supervision Series .	Audrey Boggs, Psy.D	22	1,4	1,2,3
July 16	Conversations on Gangs and the Justice System	Jose and Elizabeth Quiroz	16	1,2,3,4,5	1,2,3,4,8,9
July 25	Youth Mental Health Academy – Day 1 System of Care for Children and Youth	Susan Castillo, MSW, CHC Melissa Ladrech, LMFT Phyllis King, LMFT VOICES NAMI	12	1,3,4	3,5,8,9
July 26	Youth Mental Health Academy – Day 2 Question, Persuade, Refer	Wendy Tappon, MFTi, Cynthia Morfin	12	1,3,4	3,5,8,9
July 27	Youth Mental Health Academy – Day 3 Mental Health and School	Susan Castillo, MSW CHC Amy Faulstich, MSW Katie Bivin, LMFT SCOE: Debra Sanders	15	1,3,4	3,5,8,9

		SELPA: John Fischer			
July 28	Youth Mental Health Academy – Day 4 Youth Rights Trauma Informed Care Suicide Prevention	Michael Kozart, MD Megan Burns, MD Tamara Winer, LCSW Karin Sellite, LCSW Katie Bivin, LMFT Melonie Lopes, MSW	13	1,3,4	3,5,8,9
July 29	Youth Mental Health Academy – Day 5 - Mental Health First Aid	Cruz Cavallo, LMFT Melissa Ladrech, LMFT	11	1,3,4	3,5,8,9
Aug 3	Safety with Clients: Intuition, De-Escalation, & Home Visits	Angela Avery, Safety Coordinator Waid Allred, SCSS Stephanie Meyler, LCSW	122	4	1,2,3,4
Aug 15	DBT: Skills Group Facilitator Training – Session 1A	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Aug 18	DBT: Skills Group Facilitator Training – Session 1B	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Aug 22	DBT: Skills Group Facilitator Training – Session 2A	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Aug 25	DBT: Skills Group Facilitator Training – Session 2B	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Aug 29	DBT: Skills Group Facilitator Training – Session 3A	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Sept 1	DBT: Skills Group Facilitator Training – Session 3B	Melissa Ladrech, LMFT Laura Porter, LMFT	unavailable	1,3,4,5	2,3
Sept 7	Assessing and Managing Suicide Risk	Katie Bivin, LMFT Melissa Ladrech, LMFT	34	2,3	2,3,9
Sept 9	Serving Veterans through Partnership	Peter Stuart, MD Veteran's Administration	9	1,2,3,4,5	1,2,3,4,8,9
Sept 12	Master Clinical Supervision Series	Audrey Boggs, Psy.D.	16	1,4	1,2,3
Sept 26	Special Needs of Teen and Transition Age Youth	Jason Gallock – Wellness and Advocacy Center: Quarter Life Group Coordinator Rafeal Velasquez – EOP SRJC	Unavailable	1,2,3,4,5	1,2,3,4,8,9
Sept 28	Documentation Training	Audrey Boggs, Psy.D.	131	2,3	1,2,4
Oct 5	5150 Training	Michael Kozart, MD Tamara Winer, LCSW PRA	19	2,4,5	2
Oct 10	Overview of Psychiatric Rehabilitation Approach	Deborah Nicolellis, MS, CRC, CPRP- Boston University Center for Psychiatric Rehabilitation	213	1,4,5	1,2,3,9

Oct 11	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	23	1,4,5	1,9
Oct 12	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	31	1,4,5	1,2,3,9
Oct 13	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	20	1,4,5	1,2,3,9
Oct 14	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	20	1,4,5	1,2,3,9
Oct 17	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	18	1,4,5	1,2,3,9
Oct 18	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	18	1,4,5	1,2,3,9
Oct 18	Local Petaluma/South County Issues	Amy Faulstich – MHSA Coordinator	Unavailable	12,3,4,5	1,2,3,4,8,9
Oct 27	Outreach Efforts	Susan Castillo, Section Manager Cruz Cavallo, LMFT	23	1,3,4	1,2,3,4,8,9
Nov 7	DBT: Skills Group Facilitator Training – Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	8	1,3,4,5	2,3
Nov 10	DBT: Skills Group Facilitator Training – Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT	9	1,3,4,5	2,3
Nov 11	Psychiatric Rehabilitation Approach: Webinar – Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	19	1,4,5	1,2,3,9
Nov 12	Psychiatric Rehabilitation Approach: Webinar – Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	18	1,4,5	1,2,3,9
Nov 14	Master Clinical Supervision Series .	Audrey Boggs, Psy.D	19	1,4	1,2,3

Nov 14	Psychiatric Rehabilitation Approach: Readiness Development and Choosing Overview	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	38	1,4,5	1,2,3,9
Nov 15	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP – Boston University Center for Psychiatric Rehabilitation	20	1,4,5	1,2,3,9
Nov 15	AB 402 Continuum of Care Reform CCR	Nick Honey – Human Services Division Director Mike Kennedy – Behavioral Health Director	unavailable	1,2,3,4,5	1,2,3,4,8,9
Nov 16	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	19	1,4,5	1,2,3,9
Nov 17	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	19	1,4,5	1,2,3,9
Nov 18	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	17	1,4,5	1,2,3,9
Nov 28	DBT: Skills Group Facilitator Training – Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT	10	1,3,4,5	2,3
Nov 30	DSM-5	Kristin Dempsey, CA Institute for Behavioral Health Solutions	133	1,2,3,4,5	1,2,3
Dec 1	DBT: Skills Group Facilitator Training – Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
Dec 5	DBT: Skills Group Facilitator Training – Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	10	1,3,4,5	2,3
Dec 7	Gender & Sexuality	Javier Riviera, Program Manager Positive Images	119	1,2,3,4,5	1,2,3,4,5,6,8,9
Dec 8	5150 Training	Michael Kozart, MD Tamara Winer, LCSW, PRA	20	2,4,5	2
Dec 8	DBT Facilitator Training: Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT	8	1,3,4,5	2,3
Dec 12	DBT Facilitator Training: Session 7A	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
Dec 13	PRA Webinar TA Case Review Implementation	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	16	1,4,5	1,2,3,9
Dec 14	PRA Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University	16	1,4,5	1,2,3,9

		Center for Psychiatric Rehabilitation			
Dec 15	DBT Facilitator Training: Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT	8	1,3,4,5	2,3
Dec 19	DBT Facilitator Training: Session 8A	Wendy Wheelwright, LMFT Laura Porter, LMFT	6	1,3,4,5	2,3
Dec 22	DBT Facilitator Training: Session 8B	Wendy Wheelwright, LMFT Laura Porter, LMFT	6	1,3,4,5	2,3
Jan 9	DBT Facilitator Training: Session 9A	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
Jan 9	Master Clinical Supervision Series: Session VII	Audrey Boggs, Psy.D.	17	1,4	1,2,3
Jan 10	Team Training YFS: Documentation	Wendy Wheelwright, LMFT	unavailable	1,2,3,4	1,2,4
Jan 11	Minor Consent	Linda Garrett, JD	86	2,3,4	1,2,3,9
Jan 12	DBT Facilitator Training: Session 9B	Wendy Wheelwright, LMFT Laura Porter, LMFT	9	1,3,4,5	2,3
Jan 17	Local Sonoma Valley Issues	Karin Sellite – CAPE Coordinator Kathie Tunstall – CMHC Sonoma Program Manager	unavailable	1,2,3,4,5	1,2,3,4,5,9
Jan 23	DBT Facilitator Training: Session 10A	Wendy Wheelwright, LMFT Laura Porter, LMFT	9	1,3,4,5	2,3
Jan 26	Cultural Responsiveness Committee: Mental Health Recovery	Peer Panel	21	1,2,3,4,5	1,2,3,4,5,9
Jan 26	DBT Facilitator Training: Session 10B	Wendy Wheelwright, LMFT Laura Porter, LMFT	10	1,3,4,5	2,3
Jan 26	CMHL: Let's Take A Walk On The Wild Side – The Human Animal Bond	Dr. Gillian Squirrel, BA, MA,MBA, MSc, MS, PhD, CPCC, PGCE and RCH, RSA – Social Science in Action	34	1,2,3,4,5	1,2,3,4,5,8,9
Jan 30	DBT Facilitator Training: Session 11A	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
Feb 1	Law & Ethics	Linda Garrett, JD	145	3,4	1,2,3
Feb 2	Team Training CSU: DSM5	Wendy Wheelwright, LMFT	9	1,3,4	1,2,4
Feb 2	Team Training FACT: DSM5	Wendy Wheelwright, LMFT	6	1,3,4	1,2,4
Feb 2	DBT Facilitator Training: Session 11B	Wendy Wheelwright, LMFT Laura Porter, LMFT	10	1,3,4,5	2,3

Feb 6	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	15	1,4,5	1,2,3,9
Feb 6	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	11	1,4,5	1,2,3,9
Feb 6	Team Training CSU: DSM5	Wendy Wheelwright, LMFT	9	1,3,4	1,2,4
Feb 7	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	15	1,4,5	1,2,3,9
Feb 8	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	15	1,4,5	1,2,3,9
Feb 9	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	14	1,4,5	1,2,3,9
Feb 10	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	16	1,4,5	1,2,3,9
Feb 15	Team Training MADF: DSM5	Wendy Wheelwright, LMFT	unavailable	1,3,4	1,2,4
Feb 21	Cultural Diversity & Competency	Susan Castillo – Community Behavioral Health Section Manager Cruz Lopez – CIP Program Manager	unavailable	1,2,3,4,5	1,2,3,4,5,8,9
Feb 23	Team Training Access: DSM5	Wendy Wheelwright, LMFT	5	1,3,4	1,2,4
Feb 23	CMHL: Human Sexuality in the Context of Mental Health Recovery	Wendy Wheelwright, LMFT	23	1,2,3,4,5	1,2,3,4,5,8,9
Feb 24	Assessing and Managing Suicide Risk	Cruz Lopez, LMFT Melissa Ladrech, LMFT	18	2,3,4	2,3
Feb 27	DBT Facilitator Training: Session 12A	Wendy Wheelwright, LMFT Laura Porter, LMFT	12	1,3,4,5	2,3
Feb 28	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	10	1,4,5	1,2,3,9
Mar 1	Peer Perspectives: Releasing Hope	Susan Standen	130	1,2,3,4,5	1,2,4

Mar 2	Team Training FACT: Documentation	Wendy Wheelwright, LMFT	6	1,3,4	1,2,4
Mar 2	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	11	1,4,5	1,2,3,9
Mar 2	DBT Facilitator Training: Session 12B	Cruz Lopez, LMFT Melissa Ladrech, LMFT	6	1,3,4,5	2,3
Mar 2	Team Training Access: Documentation	Wendy Wheelwright, LMFT	8	1,3,4	1,2,4
Mar 13	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	14	1,4,5	1,2,3,9
Mar 13	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	12	1,4,5	1,2,3,9
Mar 14	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	16	1,4,5	1,2,3,9
Mar 14	Team Training YFS: DSM5	Wendy Wheelwright, LMFT	16	1,3,4	1,2,4
Mar 15	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	14	1,4,5	1,2,3,9
Mar 16	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	15	1,4,5	1,2,3,9
Mar 17	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	14	1,4,5	1,2,3,9
Mar 20	DBT Facilitator Training: Didactic Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT	10	1,3,4,5	2,3
Mar 22	Contractor Training Seneca: DSM5	Wendy Wheelwright, LMFT	15	1,3,4	3
Mar 22	Team Training MST: DSM5 & Documentation	Wendy Wheelwright, LMFT	10	1,3,4	1,2,3
Mar 23	Cultural Responsiveness Committee: HIV	Meghan Murphy, MSW – Program Director: Face to Face	16	1,2,3,4,5	1,2,3,4,5,8,9

Mar 23	DBT Facilitator Training: Didactic Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT	6	1,3,4,5	2,3
Mar 23	Team Training MSM: DSM5	Wendy Wheelwright, LMFT	6	1,3,4	2
Mar 23	CMHL: The Impact of HIV on Sex and Sexuality	Meghan Murphy, MSW – Face to Face	24	1,2,3,4,5	1,2,3,4,5,8,9
Mar 27	DBT Facilitator Training: Consultation Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT	6	1,3,4,5	2,3
Mar 30	DBT Facilitator Training: Consultation Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT	3	1,3,4,5	2,3
Mar 30	Team Training Access: Documentation	Wendy Wheelwright, LMFT	8	1,3,4	2,3
Apr 3	DBT Facilitator Training: Didactic Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT	9	1,3,4,5	2,3
Apr 4	Team Training YFS: Documentation	Wendy Wheelwright, LMFT	14	1,3,4	1,2,4
Apr 5	Cultural Competency: Working with Latino Communities	Latino Service Providers	126	1,2,3,4,5	1,2,3,4,5,8,9
Apr 5	5150 Training	Michael Kozart, MD Tamara Winer, LCSW, PRA	13	1,3,4	3
Apr 6	DBT Facilitator Training: Didactic Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT	5	1,3,4,5	2,3
Apr 7	Team Training IHT: Documentation	Wendy Wheelwright, LMFT	7	1,3,4	1,2,4
Apr 10	DBT Facilitator Training: Consultation Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
Apr 11	Team Training CAPE: DSM5 & Documentation	Wendy Wheelwright, LMFT	12	1,3,4	1,2,4
Apr 13	Team Training OAT: Documentation	Wendy Wheelwright, LMFT	10	1,3,4	1,2,4
Apr 13	DBT Facilitator Training: Consultation Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT	4	1,3,4,5	2,3
Apr 17	DBT Facilitator Training: Didactic Session 3A	Wendy Wheelwright, LMFT Laura Porter, LMFT	9	1,3,4,5	2,3
Apr 18	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University	8	1,4,5	1,2,3,9

		Center for Psychiatric Rehabilitation			
Apr 18	Cloverdale/North County Issues	Cruz Lopez – CIP Program Manager Erica Fromway – Support Our Students – Project SUCCESS +	unavailable	1,2,3,4,5	1,2,3,4,5,8,9
Apr 19	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	9	1,4,5	1,2,3,9
Apr 20	DBT Facilitator Training: Didactic Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT	5	1,3,4,5	2,3
Apr 24	DBT Facilitator Training: Consultation Session 3A	Wendy Wheelwright, LMFT Laura Porter, LMFT	3	1,3,4,5	2,3
Apr 27	DBT Facilitator Training: Consultation Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT	3	1,3,4,5	2,3
Apr 27	CMHL: Human Sexuality – Understanding Sexual Pleasure	Dr. Daniela Dominguez, Ph.D. – University of San Francisco: Santa Rosa Branch Coordinator	25	1,2,3,4,5	1,2,3,4,5,8,9
May 1	DBT Facilitator Training: Didactic Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	11	1,3,4,5	2,3
May 3	Compassion Fatigue	Sean Kelson, Manager – Interlink Self Help Center, Petaluma Peer Recovery Project Meghan Murphy, MSW Face to Face Jane Paul, LMFT Wendy Wheelwright, LMFT	61	1,2,3,4,5	1,2,4
May 4	DBT Facilitator Training: Didactic Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT	5	1,3,4,5	2,3
May 8	DBT Facilitator Training: Consultation Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	5	1,3,4,5	2,3
May 8	Master Clinical Supervision Series: Session VIII	Wendy Wheelwright, LMFT	21	1,4	1,2,3
May 9	BH Roundtable: The Future of Foster Family Agencies under CCR	Christina Amarant, LMFT	6	4.5	2,3,4,9
May 9	BH Roundtable: The Future of Short Term Residential Treatment Programs under CCR	Christina Amarant, LMFT	9	4.5	2,3,4,9
May 11	DBT Facilitator Training: Consultation Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT	2	1,3,4,5	2,3

May 15	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	16	1,4,5	1,2,3,9
May 15	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	13	1,4,5	1,2,3,9
May 16	Psychiatric Rehabilitation Approach, Cohort B: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	15	1,4,5	1,2,3,9
May 17	Psychiatric Rehabilitation Approach, Cohort A: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	13	1,4,5	1,2,3,9
May 18	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	13	1,4,5	1,2,3,9
May 19	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	14	1,4,5	1,2,3,9
May 19	Assessing and Managing Suicide Risk	Melissa Ladrech, LMFT Patricia Mills, LMFT	18	2,3,4	2,3
May 22	DBT Facilitator Training: Didactic Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT	7	1,3,4,5	2,3
May 25	DBT Facilitator Training: Didactic Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT	3	1,3,4,5	2,3
May 25	CMHL: Human Sexuality – Transgender Medicine	Dr. Suegee Tamar-Mattis, MD Santa Rosa Community Health Centers Dr. Shawn Giamattei, PhD Quest Family Therapy – Santa Rosa	25	1,2,3,4,5	1,2,3,4,5,8,9
May 30	Mental Health First Aid	Cruz Lopez, LMFT Melissa Ladrech, LMFT	unavailable	2.3.4.5	3,5,9
May 31	Mental Health First Aid	Cruz Lopez, LMFT Melissa Ladrech, LMFT	unavailable	2.3.4.5	3,5,9
Jun 7	ACEs and Resiliency	Grace Harris, LMFT Clinical Director – Child Parent Institute	48	1,2,3,4,5	1,2,3,4,5,8,9
Jun 8	DBT Facilitator Training: Consultation Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT	4	1,3,4,5	2,3

Jun 12	DBT Facilitator Training: Didactic Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	4	1,3,4,5	2,3
Jun 13	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	11	1,4,5	1,2,3,9
Jun 14	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	8	1,4,5	1,2,3,9
Jun 15	DBT Facilitator Training: Didactic Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT	4	1,3,4,5	2,3
Jun 22	DBT Facilitator Training: Consultation Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	4	1,3,4,5	2,3
Jun 22	CMHL: Alcoholics Anonymous	Sonoma County Public Information and Cooperation with the Professional Communities Committee	25	1,2,3,4,5	1,2,3,4,5,8,9
Jun 29	DBT Facilitator Training: Didactic Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT	5	1,3,4,5	2,3

III. **Counties must have a process of the incorporation of Client Culture Training throughout the mental health system.**

The county shall include the following in the CCRP:

A. Evidence of an annual training on Client Culture that included a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topic for Client Culture training may include the following:

- Culture-specific expressions of distress (e.g. nervious);
- Explanatory models of treatment pathways (e.g. indigenous healers);
- Relationship between client and mental health provider from a cultural perspective;
- Trauma;
- Economic impact;
- Housing;
- Diagnosis/labeling;
- Medication;
- Hospitalization;
- Societal/familial/personal;
- Discrimination/stigma;
- Effects of culturally and linguistically incompetent services;

- Involuntary treatment;
- Wellness;
- Recovery; and
- Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.

Training Date	Description of Training	Presenter
July 25	Youth Mental Health Academy – Day 1 System of Care for Children and Youth	Susan Castillo, MSW, CHC Melissa Ladrech, LMFT Phyllis King, LMFT VOICES NAMI
July 26	Youth Mental Health Academy – Day 2 Question, Persuade, Refer	Wendy Tappon, MFTi, Cynthia Morfin
July 27	Youth Mental Health Academy – Day 3 Mental Health and School	Susan Castillo, MSW CHC Amy Faulstich, MSW Katie Bivin, LMFT SCOE: Debra Sanders SELPA: John Fischer
July 28	Youth Mental Health Academy – Day 4 Youth Rights Trauma Informed Care Suicide Prevention	Michael Kozart, MD Megan Burns, MD Tamara Winer, LCSW Karin Sellite, LCSW Katie Bivin, LMFT Melonie Lopes, MSW
July 29	Youth Mental Health Academy – Day 5 – Youth Mental Health First Aid	Cruz Cavallo, LMFT Melissa Ladrech, LMFT
Aug 3	Safety with Clients: Intuition, De-Escalation, & Home Visits	Angela Avery, Safety Coordinator Waid Allred, SCSS Stephanie Meyler, LCSW
Aug 15	DBT: Skills Group Facilitator Training – Session 1A	Melissa Ladrech, LMFT Laura Porter, LMFT
Aug 18	DBT: Skills Group Facilitator Training – Session 1B	Melissa Ladrech, LMFT Laura Porter, LMFT
Aug 22	DBT: Skills Group Facilitator Training – Session 2A	Melissa Ladrech, LMFT Laura Porter, LMFT
Aug 25	DBT: Skills Group Facilitator Training – Session 2B	Melissa Ladrech, LMFT Laura Porter, LMFT
Aug 29	DBT: Skills Group Facilitator Training – Session 3A	Melissa Ladrech, LMFT Laura Porter, LMFT
Sept 1	DBT: Skills Group Facilitator Training – Session 3B	Melissa Ladrech, LMFT Laura Porter, LMFT
Sept 7	Assessing and Managing Suicide Risk	Katie Bivin, LMFT Melissa Ladrech, LMFT
Oct 10	Overview of Psychiatric Rehabilitation Approach	Deborah Nicolellis, MS, CRC, CPRP- Boston University Center for Psychiatric Rehabilitation

Oct 11	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Oct 12	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Oct 13	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Oct 14	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Oct 17	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Oct 18	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 7	DBT: Skills Group Facilitator Training – Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Nov 10	DBT: Skills Group Facilitator Training – Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Nov 11	Psychiatric Rehabilitation Approach: Webinar – Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 12	Psychiatric Rehabilitation Approach: Webinar – Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 14	Psychiatric Rehabilitation Approach: Readiness Development and Choosing Overview	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 15	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP – Boston University Center for Psychiatric Rehabilitation
Nov 16	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 17	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 18	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Nov 28	DBT: Skills Group Facilitator Training – Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Nov 30	DSM-5	Kristin Dempsey, CA Institute for Behavioral Health Solutions
Dec 1	DBT: Skills Group Facilitator Training – Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Dec 5	DBT: Skills Group Facilitator Training – Session 6A	Wendy Wheelwright, LMFT

		Laura Porter, LMFT
Dec 7	Gender & Sexuality	Javier Riviera, Program Manager Positive Images
Dec 8	DBT Facilitator Training: Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Dec 12	DBT Facilitator Training: Session 7A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Dec 13	PRA Webinar TA Case Review Implementation	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Dec 14	PRA Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Dec 15	DBT Facilitator Training: Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Dec 19	DBT Facilitator Training: Session 8A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Dec 22	DBT Facilitator Training: Session 8B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jan 9	DBT Facilitator Training: Session 9A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jan 11	Minor Consent	Linda Garrett, JD
Jan 12	DBT Facilitator Training: Session 9B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jan 23	DBT Facilitator Training: Session 10A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jan 26	DBT Facilitator Training: Session 10B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jan 30	DBT Facilitator Training: Session 11A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Feb 1	Law & Ethics	Linda Garrett, JD
Feb 2	DBT Facilitator Training: Session 11B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Feb 6	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Feb 6	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Feb 7	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Feb 8	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Feb 9	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Feb 10	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation

Feb 23	CMHL: Human Sexuality in the Context of Mental Health Recovery	Wendy Wheelwright, LMFT
Feb 24	Assessing and Managing Suicide Risk	Cruz Lopez, LMFT Melissa Ladrech, LMFT
Feb 27	DBT Facilitator Training: Session 12A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Feb 28	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 2	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 2	DBT Facilitator Training: Session 12B	Cruz Lopez, LMFT Melissa Ladrech, LMFT
Mar 13	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 13	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 14	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 14	Team Training YFS: DSM5	Wendy Wheelwright, LMFT
Mar 15	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 16	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 17	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Mar 20	DBT Facilitator Training: Didactic Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Mar 22	Contractor Training Seneca: DSM5	Wendy Wheelwright, LMFT
Mar 23	Cultural Responsiveness Committee: HIV	Meghan Murphy, MSW – Face to Face
Mar 23	DBT Facilitator Training: Didactic Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Mar 27	DBT Facilitator Training: Consultation Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Mar 30	DBT Facilitator Training: Consultation Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 3	DBT Facilitator Training: Didactic Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 4	Team Training YFS: Documentation	Wendy Wheelwright, LMFT

Apr 5	Cultural Competency: Working with Latino Communities	Latino Service Providers
Apr 6	DBT Facilitator Training: Didactic Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 10	DBT Facilitator Training: Consultation Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 11	Team Training CAPE: DSM5 & Documentation	Wendy Wheelwright, LMFT
Apr 13	DBT Facilitator Training: Consultation Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 17	DBT Facilitator Training: Didactic Session 3A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 18	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Apr 19	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Apr 20	DBT Facilitator Training: Didactic Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 24	DBT Facilitator Training: Consultation Session 3A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Apr 27	DBT Facilitator Training: Consultation Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 1	DBT Facilitator Training: Didactic Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 4	DBT Facilitator Training: Didactic Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 8	DBT Facilitator Training: Consultation Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 9	BH Roundtable: The Future of Foster Family Agencies under CCR	Christina Amarant, LMFT
May 9	BH Roundtable: The Future of Short Term Residential Treatment Programs under CCR	Christina Amarant, LMFT
May 11	DBT Facilitator Training: Consultation Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 15	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
May 15	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
May 16	Psychiatric Rehabilitation Approach, Cohort B: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
May 17	Psychiatric Rehabilitation Approach, Cohort A: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation

May 18	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
May 19	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
May 19	Assessing and Managing Suicide Risk	Melissa Ladrech, LMFT Patricia Mills, LMFT
May 22	DBT Facilitator Training: Didactic Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT
May 25	DBT Facilitator Training: Didactic Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 5	DBT Facilitator Training: Consultation Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 7	ACEs and Resiliency	Grace Harris, LMFT Clinical Director – Child Parent Institute
Jun 8	DBT Facilitator Training: Consultation Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 12	DBT Facilitator Training: Didactic Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 13	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Jun 14	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation
Jun 15	DBT Facilitator Training: Didactic Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 19	DBT Facilitator Training: Consultation Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 22	DBT Facilitator Training: Consultation Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 26	DBT Facilitator Training: Didactic Session 7A	Wendy Wheelwright, LMFT Laura Porter, LMFT
Jun 29	DBT Facilitator Training: Didactic Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT

B. The training plan must also include for children, adolescents, and transition age youth, the parent's and/or caretakers, personal experiences with the following:

1. Family Focused treatment
2. Navigating multiple agency services; and
3. Resiliency

Training Date	Description of Training	Presenter	Training Focus (Topics # from list 5.III.A above)

July 25	Youth Mental Health Academy – Day 1 System of Care for Children and Youth	Susan Castillo, MSW, CHC Melissa Ladrech, LMFT Phyllis King, LMFT VOICES NAMI	1,2
July 26	Youth Mental Health Academy – Day 2 Question, Persuade, Refer	Wendy Tappon, MFTi, Cynthia Morfin	3
July 27	Youth Mental Health Academy – Day 3 Mental Health and School	Susan Castillo, MSW CHC Amy Faulstich, MSW Katie Bivin, LMFT SCOE: Debra Sanders SELPA: John Fischer	2,3
July 28	Youth Mental Health Academy – Day 4 Youth Rights Trauma Informed Care Suicide Prevention	Michael Kozart, MD Megan Burns, MD Tamara Winer, LCSW Karin Sellite, LCSW Katie Bivin, LMFT Melonie Lopes, MSW	1,2,3
July 29	Youth Mental Health Academy – Day 5 - Mental Health First Aid	Cruz Cavallo, LMFT Melissa Ladrech, LMFT	1,2,3
Aug 3	Safety with Clients: Intuition, De-Escalation, & Home Visits	Angela Avery, Safety Coordinator Waid Allred, SCSS Stephanie Meyler, LCSW	3
Aug 15	DBT: Skills Group Facilitator Training – Session 1A	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Aug 18	DBT: Skills Group Facilitator Training – Session 1B	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Aug 22	DBT: Skills Group Facilitator Training – Session 2A	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Aug 25	DBT: Skills Group Facilitator Training – Session 2B	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Aug 29	DBT: Skills Group Facilitator Training – Session 3A	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Sept 1	DBT: Skills Group Facilitator Training – Session 3B	Melissa Ladrech, LMFT Laura Porter, LMFT	1,2,3
Sept 7	Assessing and Managing Suicide Risk	Katie Bivin, LMFT Melissa Ladrech, LMFT	1,2,3
Oct 10	Overview of Psychiatric Rehabilitation Approach	Deborah Nicolellis, MS, CRC, CPRP- Boston University Center for Psychiatric Rehabilitation	1,3
Oct 11	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Oct 12	Psychiatric Rehabilitation Approach: Managers and Supervisors	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Oct 13	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3

Oct 14	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort A Deborah Nicolellis, MS, CRC, CPRP	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Oct 17	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Oct 18	Psychiatric Rehabilitation Approach: Readiness Assessment and Development – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 7	DBT: Skills Group Facilitator Training – Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Nov 10	DBT: Skills Group Facilitator Training – Session 4B Wendy Wheelwright, LMFT Laura Porter, LMFT	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Nov 11	Psychiatric Rehabilitation Approach: Webinar – Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 12	Psychiatric Rehabilitation Approach: Webinar – Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 14	Psychiatric Rehabilitation Approach: Readiness Development and Choosing Overview	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 15	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort A	Deborah Nicolellis, MS, CRC, CPRP – Boston University Center for Psychiatric Rehabilitation	1,3
Nov 16	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort A	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 17	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 1 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 18	Psychiatric Rehabilitation Approach: Readiness Development and Choosing – Day 2 Cohort B	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Nov 28	DBT: Skills Group Facilitator Training – Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 1	DBT: Skills Group Facilitator Training – Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 5	DBT: Skills Group Facilitator Training – Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 7	Gender & Sexuality	Javier Riviera, Program Manager Positive Images	
Dec 8	DBT Facilitator Training: Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 12	DBT Facilitator Training: Session 7A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 13	PRA Webinar TA Case Review Implementation	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3

Dec 14	PRA Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Dec 15	DBT Facilitator Training: Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 19	DBT Facilitator Training: Session 8A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Dec 22	DBT Facilitator Training: Session 8B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jan 9	DBT Facilitator Training: Session 9A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jan 11	Minor Consent	Linda Garrett, JD	1
Jan 12	DBT Facilitator Training: Session 9B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jan 23	DBT Facilitator Training: Session 10A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jan 26	DBT Facilitator Training: Session 10B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jan 30	DBT Facilitator Training: Session 11A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Feb 1	Law & Ethics	Linda Garrett, JD	1
Feb 2	DBT Facilitator Training: Session 11B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Feb 6	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 6	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 7	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 8	Psychiatric Rehabilitation Approach, Cohort A: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 9	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 10	Psychiatric Rehabilitation Approach, Cohort B: Functional Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Feb 23	CMHL: Human Sexuality in the Context of Mental Health Recovery	Wendy Wheelwright, LMFT	1,3

Feb 24	Assessing and Managing Suicide Risk	Cruz Lopez, LMFT Melissa Ladrech, LMFT	3
Feb 27	DBT Facilitator Training: Session 12A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Feb 28	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 2	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 2	DBT Facilitator Training: Session 12B	Cruz Lopez, LMFT Melissa Ladrech, LMFT	1,2,3
Mar 13	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 13	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 14	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 15	Psychiatric Rehabilitation Approach, Cohort A: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 16	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 17	Psychiatric Rehabilitation Approach, Cohort B: Direct Skills Teaching	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Mar 20	DBT Facilitator Training: Didactic Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Mar 23	DBT Facilitator Training: Didactic Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Mar 27	DBT Facilitator Training: Consultation Session 1A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Mar 30	DBT Facilitator Training: Consultation Session 1B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 3	DBT Facilitator Training: Didactic Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 5	Cultural Competency: Working with Latino Communities	Latino Service Providers	1,2,3
Apr 6	DBT Facilitator Training: Didactic Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 10	DBT Facilitator Training: Consultation Session 2A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 13	DBT Facilitator Training: Consultation Session 2B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 17	DBT Facilitator Training: Didactic Session 3A	Wendy Wheelwright, LMFT	1,2,3

		Laura Porter, LMFT	
Apr 18	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Apr 19	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Apr 20	DBT Facilitator Training: Didactic Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 24	DBT Facilitator Training: Consultation Session 3A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Apr 27	DBT Facilitator Training: Consultation Session 3B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 1	DBT Facilitator Training: Didactic Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 4	DBT Facilitator Training: Didactic Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 8	DBT Facilitator Training: Consultation Session 4A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 9	BH Roundtable: The Future of Foster Family Agencies under CCR	Christina Amarant, LMFT	1,2,3
May 9	BH Roundtable: The Future of Short Term Residential Treatment Programs under CCR	Christina Amarant, LMFT	1,2,3
May 11	DBT Facilitator Training: Consultation Session 4B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 15	Psychiatric Rehabilitation Approach, Cohort A: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 15	Psychiatric Rehabilitation Approach, Cohort B: Implementation Planning	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 16	Psychiatric Rehabilitation Approach, Cohort B: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 17	Psychiatric Rehabilitation Approach, Cohort A: Resource Development and Assessment	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 18	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 19	Psychiatric Rehabilitation Approach: Training for Trainers	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
May 19	Assessing and Managing Suicide Risk	Melissa Ladrech, LMFT Patricia Mills, LMFT	1,3
May 22	DBT Facilitator Training: Didactic Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
May 25	DBT Facilitator Training: Didactic Session 5B	Wendy Wheelwright, LMFT	1,2,3

		Laura Porter, LMFT	
Jun 5	DBT Facilitator Training: Consultation Session 5A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 7	ACEs and Resiliency	Grace Harris, LMFT Clinical Director – Child Parent Institute	1,2,3
Jun 8	DBT Facilitator Training: Consultation Session 5B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 12	DBT Facilitator Training: Didactic Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 13	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Jun 14	Psychiatric Rehabilitation Approach: Webinar	Deborah Nicolellis, MS, CRC, CPRP - Boston University Center for Psychiatric Rehabilitation	1,3
Jun 15	DBT Facilitator Training: Didactic Session 6B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 19	DBT Facilitator Training: Consultation Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 22	DBT Facilitator Training: Consultation Session 6A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 26	DBT Facilitator Training: Didactic Session 7A	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3
Jun 29	DBT Facilitator Training: Didactic Session 7B	Wendy Wheelwright, LMFT Laura Porter, LMFT	1,2,3

Cultural Competence Summit XX: Supporting Community Defined Practices

On March 15 and 16 2017, Sonoma County Behavioral Health in collaboration with CA Institute for Behavioral Health Solutions, and St. Joseph's Health Systems sponsored the Tenth Statewide Mental Health Cultural Competency Summit.

The theme for the Cultural Competence Summit XX is Supporting Community Defined Practices. This Summit focused on highlighting Community Defined Practices used by disparate communities to reduce stigma to increase access to mental health services and treatment throughout California counties. The conference objectives were to:

- Educate and inform attendees about effective strategies for reaching diverse populations;
- Inspire attendees to try new strategies to reach diverse populations, and
- Highlight successful activities that currently exist throughout the State that reach diverse populations.

California counties are at the forefront of providing mental health services to California's diverse population. Getting out the word about mental health services to under- and un- served communities, requires counties to "think differently" about how to accomplish this goal. While counties plan for, train, and implement, and fund evidence-based programs and practices,

reaching and serving historically un- and underserved populations necessitate alternative approaches. Using "Community Defined Evidence" (CDE) and "Practice-Based Evidence" (PBE) approaches are appropriate and necessary to gain access to these communities in order to reduce the stigma and discrimination associated with mental illness and for reaching into these unserved communities to bring their community members into care.

The 2017 Cultural Competence Summit XX offered an opportunity to learn about a range of cultural specific methodologies through workshops and presentations in order to promote learning and to advance cultural competence throughout organizations and systems with the goal of effectively meeting the diverse needs of individuals, families, and communities. This Summit was a unique opportunity to bring together people who strive to bring culturally appropriate and culturally relevant mental health care to strengthen connections and enriches the networks among stakeholders. The commitment to providing culturally competence mental health care is shared by a wide audience, particularly individuals with lived experience and their families, healthcare professionals from diverse backgrounds, managers and decision makers in leadership roles, community-based organizations, physicians (including family physicians, pediatricians, and psychiatrists), faculty and staff from academic departments, representatives from faith-based communities, and researchers and collaborators from different sectors (e.g., emergency social services, law enforcement officers, or employers).

The Honorable Patrick Kennedy served as a keynote speaker as did Kevin Berthia, a young man with lived experience. Positive Images Program Director Hosting this Summit provide an opportunity for Sonoma County Behavioral Health to showcase the hard work being done in our community to the broadest audience possible.

CRITERION 6
COUNTY MENTAL HEALTH SYSTEM
COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

I. Recruitment, hiring, and retention of a multicultural workforce from, or experience with, the identified unserved and underserved populations

The county shall include the following in the CCPR:

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce, Education, and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health System.

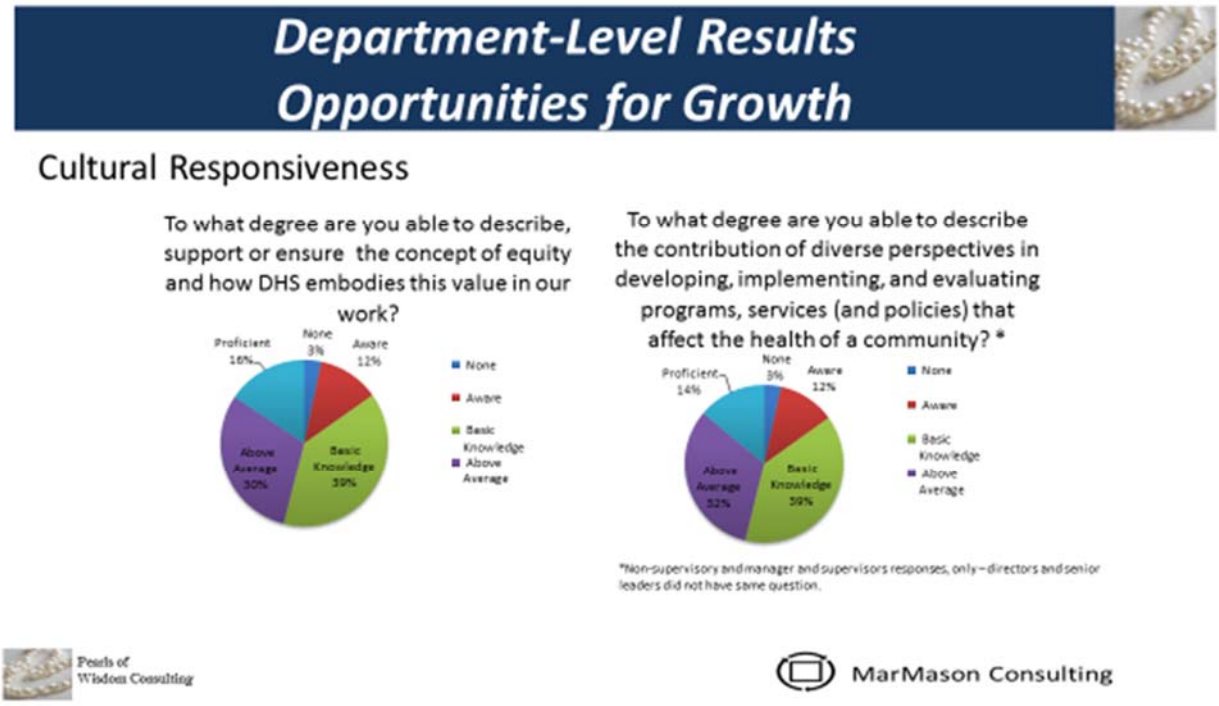
EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT - 2010

Major Group & Positions ↓	Estimated # FTE authorized	Position hard to fill 1=Yes 2= No	# FTE estimated to meet in addition to # authorized	Race/Ethnicity of FTEs currently in the workforce (from column 11)						
				White/ Caucasian	Hispanic/ Latino	African American/ Black	Asian/ Pacific Islander	Native American	Multi Racial or other	# FTE filled 5+6+7+8+9+10
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
County (employees, independent contractors, volunteers) (A+B+C+D+E)	194.0	17	80	108	13	0	5	1	5	132
All Other (CBOs. CBO sub-contractors, network providers, & volunteers) (A+B+C+D+E)	287	15	73	221	31	19	5	4	4	284
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	481	32	153	329	44	19	10	5	9	416

While Sonoma County has not implemented a Workforce Needs Assessment as outlined in the original Mental Health Services Act – Workforce, Education, and Training requirements, the MHP has participated in a number of WET assessments and surveys in an effort to determine the workforce needs of Sonoma County MHP.

In November 2013, Sonoma County MHP participated in a survey administered by CA Institute for Behavioral Health Solutions to find out what barriers, if any, exist to using Licensed Professional Clinical Counselors in county MHPs. Findings of this survey for all counties also reflect what is true for Sonoma County. Survey results can be found at: https://www.cibhs.org/sites/main/files/file-attachments/lpcc_survey_results.pdf.

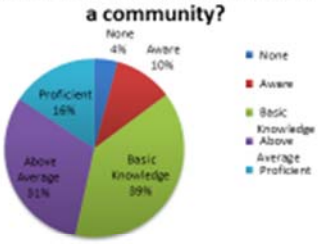
The MHP also participated in a Sonoma County Department of Health Services-wide assessment of Core Competencies needed within the behavioral health workforce. One of the core competency domains assessed was Cultural Competence. Below is a sample of summary findings from this assessment. Over the next few years, these findings will drive workforce development training for the entire department.



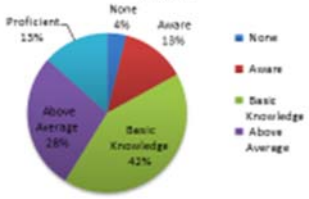
Non Supervisory Staff Opportunities for Growth

Cultural Responsiveness

To what degree are you able to describe the contribution of diverse perspectives in developing, implementing, and evaluating programs, and services that affect the health of a community?



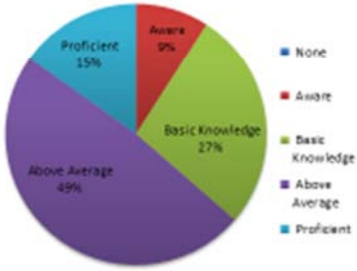
To what degree are you able to describe the concept of equity and how DHS embodies this value in our work?



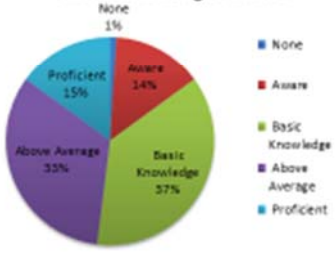
Managers and Supervisors Opportunities for Growth

Cultural Responsiveness

To what degree are you able to describe the concept of diversity as it applies to individuals and populations?



To what degree are you able to incorporate strategies into service area work for interacting with persons from diverse backgrounds?



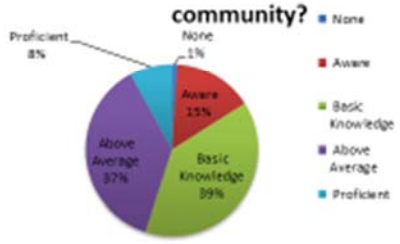
Pearls of Wisdom Consulting

MarMason Consulting

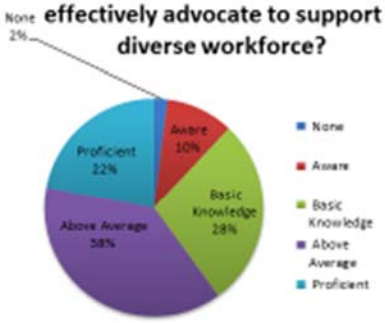
Managers and Supervisors Opportunities for Growth

Cultural Responsiveness

To what degree are you able to describe the contribution of diverse perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of a community?



To what degree are you able to effectively advocate to support a diverse workforce?



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Managers and Supervisors Opportunities for Growth

Cultural Responsiveness

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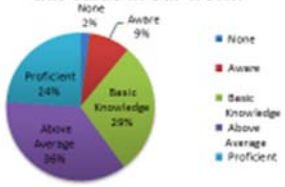

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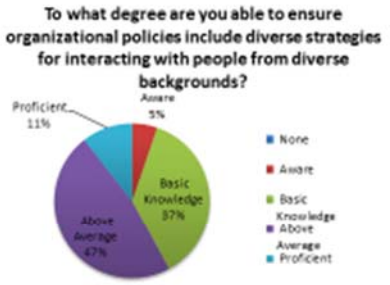
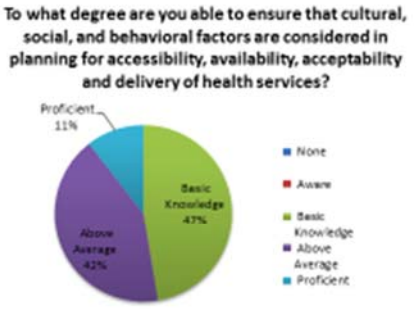
Directors and Senior Leaders – Level Results – Opportunities for Growth

Cultural Responsiveness





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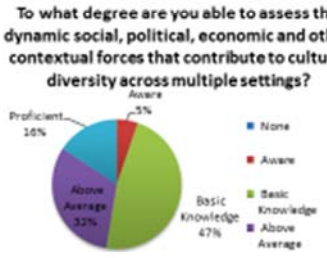
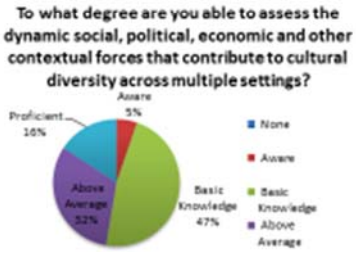
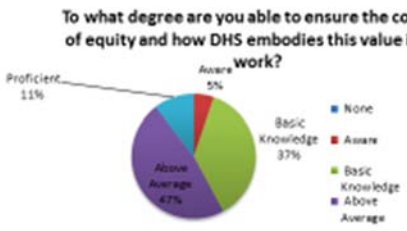
Directors and Senior Leaders – Level Results – Opportunities for Growth

Cultural Responsiveness







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B. Compare the WET Plan assessment data with the general population. Medi-Cal population and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

- The WET Plan assessment is in agreement with known shortages of Spanish-speaking, culturally diverse providers.
- In addition, the plan calls for increasing the number of mental health consumers in the public mental health system workforce.

C. If applicable, the county shall report in the CCPR the specific actions taken in response to cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

While SCBH did not receive feedback of the review of the WET Plan submission from the State, the MHP has significantly grown our WET activities to meet the needs of the consumers, staff, and community.

The Workforce Education and Training (WET) program supports the mission of the Sonoma County Behavioral Health Division (SC-BHD) to promote culturally responsive recovery and wellness of Sonoma County residents. SC-BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or substance use disorders to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-focused system include:

- Self-direction
- Individualized and person-centered care
- Empowerment and shared decision-making
- Holistic approach that encompasses mind, body, spirit, and community
- Strengths-based approach
- Peer-support
- Focus on respect, responsibility, and hope

SC-BHD fosters a collaborative approach by partnering with clients, consumers, family members, and the community to provide high quality, culturally responsive services.

SC-BHD Workforce Education and Training goals are:

- To provide staff with high quality education and training that promotes and endorses the mission of the Behavioral Health Division.
- To contribute to the development and maintenance of a culturally competent workforce, including individuals with client and family member experience who are capable of providing client and family driven services that promote wellness, recovery, and resilience.

- To teach and promote evidence-based and evidence-informed practices leading to measurable, values-driven outcomes in support of the Quality Improvement Workplan for the Behavioral Health Division.
- To encourage career development and increase job satisfaction by supporting the growth and refinement of a skillful workforce.
- To create and promote community outreach and training opportunities that encourage community stakeholder collaborations and facilitate forums for discussion and education around locally relevant behavioral health topics and needs.

WET Domains

The Workforce Education and Training program addressed the following domains:

- System Level Support
- Career Pathways
- Skill Development: Evidence-Based Practices
- Community Collaboration
- Workforce Diversification

WET Domain Components

System Level Support

<u>Accreditation</u>

Supporting the continuing education of the licensed clinical staff is vital to maintaining a skillful workforce with current and relevant practice. Accordingly, the Workforce Education and Training Coordinator is responsible for obtaining and maintaining accreditation to provide continuing education units (CEUs) for multiple clinical specialties. The accreditation process establishes and monitors course content, instructor qualifications, course evaluation, and records management. Presently, SC-BHD has obtained and maintains accreditation through the Board of Registered Nursing (BRN) and the California Association of Marriage and Family Therapists (CAMFT) for the following license types:

BRN

- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Registered Nurse (RN)
- Public Health Nurse (PHN)
- Nurse Practitioner (NP)
- Psychiatric Nurse Practitioner (PNP)

CAMFT

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)

The Workforce Education and Training Coordinator has completed an application for accreditation through the California Consortium of Addiction Programs and Professionals (CCAPP) to provide continuing education units (CEUs) to Substance Use Disorders (SUD) Services staff. Accreditation is expected April 2017. Once obtained, SC-BHD will be able to provide CEUs for the following certification types:

CCAPP

- Registered Alcohol Drug Technician (RADT)
- Certified Alcohol Drug Counselor I (CADC-I)
- Certified Alcohol Drug Counselor II (CADC-II)
- Licensed Advanced Alcohol Drug Counselor (LAADC)
- Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Over the course of the 2017-2020 plan, the WET Coordinator will pursue accreditation to provide Continuing Medical Education (CMEs) through the Accreditation Council for Continuing Medical Education (ACCME). Initial accreditation is a 1-2 year process requiring on-site evaluation by the governing body. During this process, the WET Coordinator will also pursue co-sponsorship opportunities within the community to partner with established medical education providers. This will allow CME opportunities for the following license types:

ACCME

- Psychiatrist (MD)
- Physician Assistant (PA)
- Licensed Psychologist (LPSY)

Workforce Development Plan: Core Competencies

SC-BHD is coordinating with the Public Health Division and with leadership from the Department of Health to establish and define core competencies for the Department Workforce Development Plan. This collaboration supports the Department goal of obtaining Public Health Department Accreditation. The WET Coordinator will support this process soliciting and analyzing input from Behavioral Health Division leadership to define core competencies, assess current staffing skill level within these competencies, and deliver training programs to increase critical skills. The goal is to begin the pilot assessment process by May 2017.

Regional Collaboration

The WET Coordinator participates in several networks and collaborations to stay current with best-practices and innovative ideas regarding workforce development. Additionally, the WET Coordinator monitors the Office of Statewide Health Planning and Development (OSHPD) website for funding opportunities to support WET programs.

Regional Networks

- Greater Bay Area Collaborative
- North Bay Collaborative
- WET Summit

Educational Networks

- SCOE
- University Pipeline Program
- Job/Internship Fairs

Quality Improvement

On an annual basis, the WET Coordinator and supervising Section Manager and QI Manager will meet to review the continuing education goals for the following purposes:

- To align with the mission of Sonoma County Behavioral Health Division
- To update course content to reflect current best-practices and evidence-based approaches in the field of Mental Health treatment
- To assess cultural sensitivity and relevance of training subjects
- To support new or adjusted outcomes and goals of the Quality Improvement Workplan

The WET Coordinator is responsible for maintaining current information regarding regulatory changes affecting continuing education. This includes monitoring the knowledge base underlying training content, checking the instructor qualifications, analyzing the course evaluation data, and maintaining the program records.

Knowledge Base

The WET Coordinator provides information to support the methodological, theoretical, research, and/or practice knowledge basis for the course content. This includes best-practices, theoretical models, and research citations that identify the established concepts.

Instructor Qualifications

Instructors must demonstrate expertise and knowledge in the specific content area of the course. Such expertise will be demonstrated by certification or experience in their specialty field. For Peer-Provider trainings, lived experience will substitute for academic/clinical experience. In congruence with the Sonoma County Behavioral Health Division mission, instructors are required to integrate issues of recovery, wellness, best-practice, and cultural sensitivity into their teaching.

Course Evaluation

Responses on the course evaluation forms are entered into the training database from which a statistical report is generated for review. Evaluation reports are reviewed by the training committee to identify content issues, presentation issues, and other identified areas of need. Suggested future topics and speakers from the evaluation forms are recorded in the training database and worked into the annual training curriculum where appropriate.

Training Database Project

During the 2017-2020 plan cycle, a training database will be developed to provide accurate records maintenance and to provide essential data analysis for quality improvement purposes. The following records are obtained and maintained for CE offerings:

- Contract (if applicable)
- Course description and objectives (i.e., syllabus)
- Course materials and handouts
- CV of course presenter
- Fliers and advertising
- Time and location of course
- Registration lists (for mandatory trainings)
- Sign-in and sign-out sheets (attendance rosters with names and license numbers)
- Distance-learning confirmation (by manager)
- CEU certificates issued
- Evaluations

Career Pathways

Career Ladders

The WET Coordinator will support the development of promotional opportunities with career tracks to support a Grow-Your-Own model from entry-level intern/student through supervisory leadership. This includes formalizing an internship & traineeship program, expanding the Peer-Provider program, and providing management-level training specific to the supervision of clinical interns and peer providers. Specific career ladders are as follows:

Medical

- LVN
- LPT
- Phlebotomist (proposed specialty)
- RN/PHN
- NP/PNP
- PA/MD

Clinical

- Trainee/Student Intern
- Clinical Intern (MFTi, ASW, PCCi)
- Licensed Clinician (LMFT, LCSW, LPPC)
- Clinical Specialist

Substance Use Disorders

- AODS Assistant
- AODS Counselor
- AODS Specialist

Non-Licensed

- Client Support Specialist
- Senior Client Support Specialist

Peer Provider

- Peer Support Specialist
- Consumer Education Coordinator
- Consumer Relations Coordinator

Internship & Traineeship

In support of a more skillful and to support a more diverse clinical workforce, SC-BHD is formalizing the internship and traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This includes a licensure support program, group clinical supervision, and educational outreach events. Presently, 9 new MOU's are in process with local and regional universities.

Pipeline Program

The purpose of the Pipeline Program is to cultivate interest in healthcare careers, particularly in hard-to-fill areas with high-risk populations. Additionally, the Pipeline Program preserves diversity in the workforce and reduces health disparities for the consumers. The WET Coordinator plans and participates in several community career events at both the high school and college level. Particular focus is given to encouraging Latino and bilingual students to consider Behavioral Health as a career option.

Career & Internship Fairs

The WET Coordinator, in collaboration with the Community Intervention Program, engages in outreach through internship and career fairs at Santa Rosa Junior College, Sonoma State University, and University of San Francisco. Additionally, the WET Coordinator helps plan and facilitate the annual "Mi Futuro" event in partnership with Latino Service Providers and Santa Rosa Junior College. See the following event information:

"Mi Futuro esta en Carreras de Salud: My Future is in Healthcare" is the North Bay's healthcare symposium for youth to introduce careers in Mental Health and Primary Healthcare.

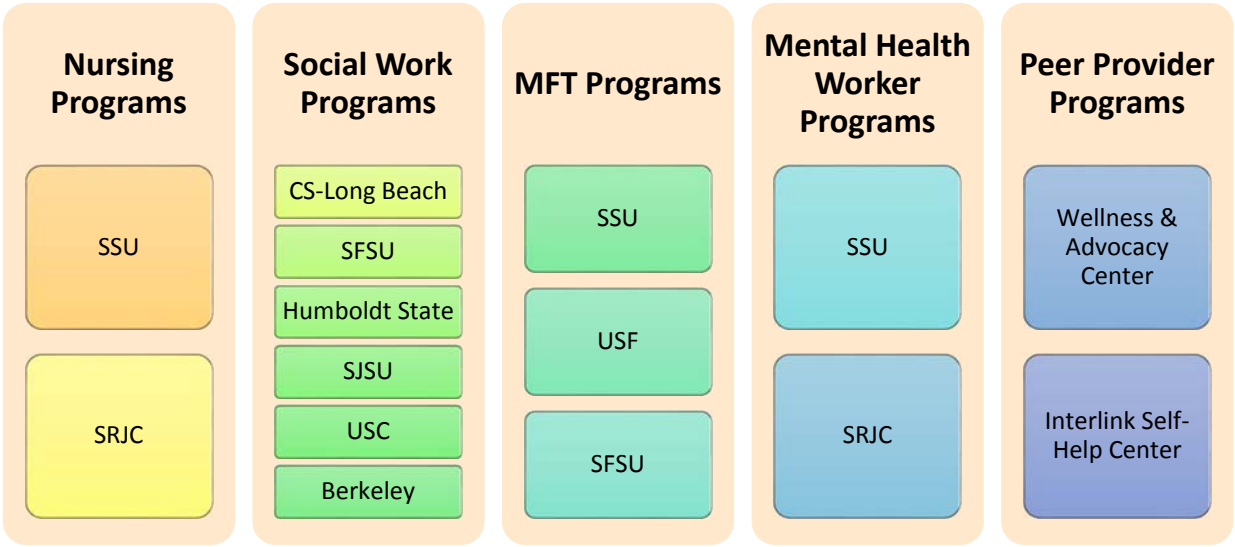
This symposium is offered to ALL youth age 16-30. However, the symposium targets Latino youth and is culturally sensitive to the unique Latino patient-care needs. Sonoma County is predicted to have a dominant Latino population by 2050. In an effort to strategically manage the local healthcare workforce

development to reflect the expected patient-care demand, *Mi Futuro* highlights and targets the Latino population.

The symposium will expose you to:

- Career opportunities in mental health & primary healthcare
- raise awareness of mental health stigmas
- The impact of mental health in primary healthcare and the community
- Interactive stations to introduce primary healthcare fields
- Dynamic speakers to plant new ideas
- Workshops and tabling will offer educational/financial resources
- Health care agencies tabling their services

Participating Universities



Licensure Support

New to SC-BHD is the Licensure Support Program designed to support clinical interns through the state exam and clinical licensure process. The WET Coordinator conducted a licensure needs assessment which identified a barrier in the examination process regarding cultural diversity of clinicians. Consequently, a test-prep support program has been developed.

Clinical Licensure Exam Support

The WET Coordinator partnered with the Therapist Development Center and with the Association for Advanced Training in the Behavioral Sciences (AATBS) to provide discounted test-prep materials for SC-BHD Interns. Additionally, the WET Coordinator will develop and facilitate a monthly test-prep support training.

Group Clinical Supervision

SC-BHD will formalize the clinical supervision process to offer on-going group supervision to clinical interns. Managers, specialists, and the WET Coordinator will rotate facilitation duties to ensure maximum exposure to a variety of clinical styles.

Master Clinical Supervision Series (MCSS)

This training program meets bi-monthly with all managers and clinical specialists to train the clinical leadership on best practices regarding clinical supervision. Topics include: models of supervision, multicultural issues in supervision, ethical and legal issues in supervision, and personal development in supervision.

Skill Development: Evidence-Based Practices

Specialty Trainings

SC-BHD sponsors selected staff, contractors, and leadership in the following training programs:

Outpatient Services	Crisis Services
•Dialectical Behavior Therapy (DBT) •Psychiatric Rehabilitation Approach (PRA)	•5150 Certification •Mandt System Training

Dialectical Behavior Therapy (DBT)

The purpose of the DBT Skills Facilitators Preparation Training series is to prepare DBT facilitators for implementation of DBT skills groups in their respective programs and provide ongoing support, feedback, and monitoring to the adherence of the DBT model. Dialectical Behavior Therapy (DBT) is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) and it is now recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders. This course focuses on the practical application of DBT Skill Group Facilitation within the wider system of care. Facilitator consultation is provided to staff implementing DBT Skills Group Facilitators to assist them in integrating and adapting whenever possible the model to be culturally responsive, trauma focused interventions, and when appropriate, family focused treatment.

Psychiatric Rehabilitation Approach (PRA)

The Psychiatric Rehabilitation Approach (PRA) is an evidence-based approach centered in recovery-oriented practice. PRA focuses on supporting people to live, learn, work, and socialize in the environments and roles of their choice. Psychiatric Rehabilitation is strengths-based and designed to help people improve their functioning and resiliency and recovery so they can be

successful and satisfied in the environment of their choice. Valued roles may include, but are not limited to: worker, volunteer, resident, homeowner, spouse, friend, trainee or student.

This training offers personnel the skills, information, and tools they need to deliver effective rehabilitation supports to people who have psychiatric disabilities. Direct service staff and contractors learn how to support people to consider, choose, get, and keep the housing, jobs, education, and social settings they want to be in, and to develop the skills and supports a person needs for success and satisfaction in those roles and settings.

5150 Certification

SC-BHD has updated the 5150 Certification Policy and is in the process of updating the Seclusion & Restraint Policy in an effort to move toward a restraint-minimal environment. This quarterly training instructs clinicians in the legal and ethical requirements of 5150 certification and supports best-practices regarding patients' rights and cultural responsiveness. The WET Coordinator has created and maintains the current 5150 certified providers list.

Mandt Training

The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. The focus of The Mandt System is on building healthy relationships between all the stakeholders in human service settings in order to facilitate the development of an organizational culture that provides the emotional, psychological, and physical safety needed in order to teach new behaviors to replace the behaviors that are labeled "challenging". Mandt training supports systems of care moving toward restraint-free environments which is especially important for those receiving involuntary treatment. Leadership staff from the Crisis Stabilization Unit participate in Mandt Train-the-Trainer and facilitate trainings within their own teams.

Team Trainings

In support of the Quality Assurance team, the WET Coordinator provides team-specific trainings on diagnostics and documentation, as well as any other topic identified in QA audits and reviews.

Diagnostics

The Diagnostic training covers the essentials of diagnostic changes in the transition between DSM-IV and DSM-5. This training includes an overview of structural changes to the DSM-5, the removal of the multi-axial system of diagnosis, specific changes to commonly used diagnosis for mental health and substance use disorders, and targeted trainings for diagnostics of children, youth, and older adults, and cultural considerations.

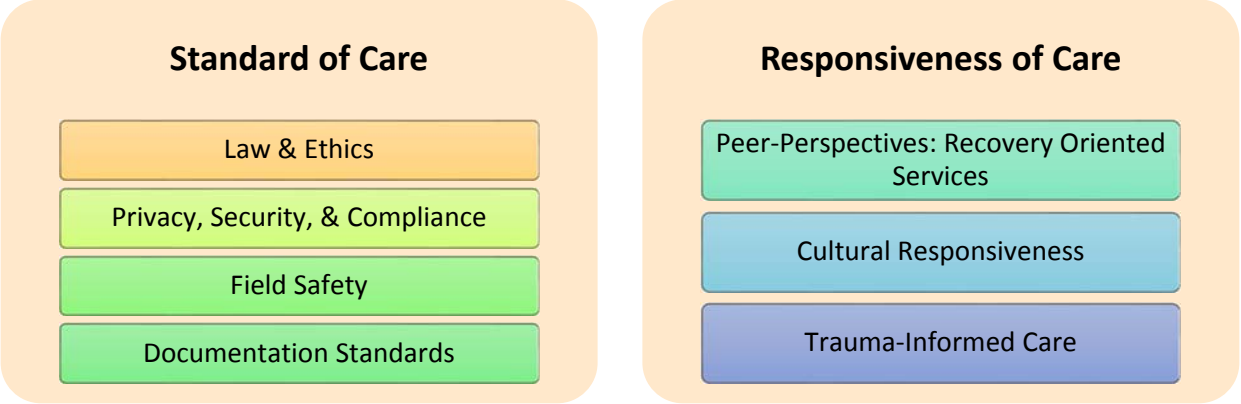
Documentation

The Documentation Training series is aimed at improving staff skill and compliance with Medi-Cal documentation standards. It focuses particularly on Medical Necessity as it filters through Assessment, Client Planning, and Progress Notes. This on-going training series supports staff to

understand how chart requirements apply to their particular program and increases adherence to charting standards. This training also strives to assist clinicians in using strengths-based, wellness and recovery focused language.

Staff Development Training Series

In response to the QI Workplan and the Cultural Responsiveness Plan, the Staff Development Training Series provides annual trainings on a core set of skills to support staff in refining their competency in legal issues, cultural awareness, and current interventions. The following topics are featured in this series:



Community Collaboration

Suicide Prevention

SC-BHD continues in its dedicated efforts to reduce suicide in Sonoma County. County Clinical staff have now been trained in AMSR (Assessing and Managing Suicide Risk) and a focused effort is being made to training Contractors as well. Additionally, QPR Training (Question, Persuade, Refer) continues to be delivered on a broad scale, covering multiple high schools, community providers, medical providers, and law enforcement.

Assessing and Managing Suicide Risk (AMSR)

AMSR is a one-day training workshop for behavioral health professionals. The 6.5-hour training program is based on the latest research and is designed to help participants provide safer suicide care. AMSR presents five of the most common dilemmas faced by providers and the best practices for addressing them. SC-BHD has dedicated trainers providing this training quarterly to all new staff and to contract providers.

Question, Persuade, Refer (QPR)

QPR Gatekeeper Training for Suicide Prevention is a 1-2 hour educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. Gatekeepers can include anyone who is strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers,

police officers). SC-BHD has certified QPR instructors delivering the training county-wide to high schools, community providers, and law enforcement.

Promoting Wellness & Recovery

The WET Coordinator supports SC-BHD and the Department of Health Services goals to create a healthier community by facilitating educational events that promote wellness and recovery. These events include Mental Health First Aid, the Youth Mental Health Academy, and the Community Mental Health Lecture Series.

Mental Health First Aid (MHFA)and Youth Mental Health First Aid (Y-MHFA)

Mental Health First Aid and Youth Mental Health First Aid is a public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect persons to the appropriate professional, peer, social, and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses, like anxiety, depression, substance use, bipolar disorder, eating disorders, and schizophrenia. Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

Youth Mental Health Academy (YMHA)

The Youth Mental Health Academy is a free week-long training held annually to increase Sonoma County youth providers' skills and capacity to work with mental health issues in adolescent populations. This interactive training week includes Youth Mental Health First Aid, System Navigation training, Trauma-Informed Care, QPR, Crisis-Response training, and Compassion Fatigue Prevention. Additionally, participants visit key service sites.

Community Mental Health Lecture Series (CMHL)

The Community Mental Health Lecture series provides free educational trainings on a monthly basis to address issues of health and wellness in Sonoma County. Experts in the field of Behavioral Health are invited to present on a wide variety of topics, such as Trauma/PTSD, Human Sexuality, Homeless Services, Outreach Services, Holistic Health, and other topics requested by the community. Presenters are required to include cultural factors specific to their topic.

Crisis Response

SC-BHD has a comprehensive crisis response plan to address crisis situations occurring in the community. The WET program supports the CIT Academy and the CAPE Team in delivering educational training for crisis situations.

Crisis Intervention Training Academy for Law Enforcement Personnel (CIT)

This 4-day, 32-hour training academy is facilitated in partnership between the Sonoma County Sheriff's Office and the Sonoma County Behavioral Health Division. The training is designed to

increase the ability of officers to intervene with mental health consumers, individuals with substance use issues, and individuals in crisis. The CIT academy is conducted twice each year. The CIT training contains Cultural Competence section that is facilitated by former Assistant Sheriff Lorenzo Duenas. Duenas currently serves as the Chief of Police for Santa Rosa Junior College District Police Department. The Cultural Competence module focuses on law enforcement personnel and community interactions.

Crisis Assessment, Prevention and Education Team (CAPE)

The Crisis Assessment, Prevention, and Education (CAPE) Team is an early intervention prevention strategy specifically designed to intervene with transitional age youth who are at risk of or are experiencing first onset of mental illness and its multiple issues and risk factors (substance use, trauma, depression, anxiety, self-harm, and suicide risk).

The CAPE Team contains 5 core components:

- ***Mobile response*** by licensed staff are available in school-based settings to provide services to TAY at-risk of or experiencing first onset of serious psychiatric illness
- ***Training*** for selected teachers, faculty, parents, counselors and law enforcement personnel to recognize the warning signs of mental illness and refer to the CAPE Team.
- ***Screening and assessment*** of at-risk youth in high schools and colleges.
- ***Peer-based services*** including youth training and counseling and support groups for at-risk youth and families.
- ***Educational activities*** for faculty, families, and youth, related to mental health education and awareness.

The WET Coordinator supports the CAPE Team in its educational and training goals by facilitating and monitoring required certifications needed by CAPE staff and scheduling regular certification opportunities for CAPE and other staff.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

   The following link provides a summary of targets for growth of a multicultural workforce. http://www.sonoma-county.org/health/about/pdf/mhsa/wet_plan.pdf.

E. Share lessons learned on efforts in rolling out WET planning and implementation efforts.

Workforce Diversification

Efforts continue to be made to recruit and retain bilingual and bicultural staff to more accurately reflect the diversity of Sonoma County. SC-BHD has contracted with Latino Service Providers to

facilitate cultural responsiveness training for County staff and community providers. Additionally, the WET Coordinator supports the "Mi Futuro" event to develop outreach and pipeline programs into the high school and junior college student populations (see above). The WET Coordinator also supports the Cultural Responsiveness Committee in providing culturally relevant trainings to County staff and the community.

The WET Coordinator partners with the Consumer Affairs Coordinator and the Consumer Education Coordinator to support peers in the workforce and expand peer-employment opportunities for people with lived-experience. The Consumer Relations Program is collaborating with the WET Coordinator to bring WISE (Workforce Integration Support and Education) training to the management team in order to facilitate best-practices in integrating peers into the workforce. The WET Coordinator also participates in the Workforce Co-Learning Collaborative (WCC) to develop curriculum for management training of peers in the workforce. In support of peer-support career pathways, the WET Coordinator participates as a trainer in the peer-support programs and facilitates cross-training opportunities between the Peer-Run Self-Help Centers (Wellness Center, Interlink, Petaluma Peer Recovery Project, Russian River Empowerment Center) and Sonoma County Behavioral Health.

F. Identify County technical assistance needs. N/A

CRITERION 7
COUNTY MENTAL HEALTH SYSTEM
LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

See the following link: http://www.sonoma-county.org/health/about/pdf/mhsa/wet_plan.pdf.

2. Updates from the Mental Health Services Act (MHSA) Community Services and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

Sonoma County Behavioral Health updates and maintains a list of Behavioral Health staff who are bilingual and available to provide interpretation services.

3. Total annual dedicated resources for interpreter services

Interpreter services are provided in non-English language by Corporate Translation Services: Language Line; Communique for the hearing impaired.

FY 16/17
$70,665.82

Because the competition for attracting and retaining skilled workers has increased significantly particularly in the areas of law enforcement, health professionals and for bilingual candidates, Sonoma County provides bi-lingual pay to certified bi-lingual staff working in specific, bilingual designated positions. In order to receive this premium staff must meet the established job qualifications and who also meet the County's bilingual certification requirements. For those who meet those requirement and who speak a necessary language, such staff receive a "bilingual premium" ranging from $0.90 per hour to $1.15 per hour, paid on all hours worked. Sonoma County Human Resources Department outlines the process for bilingual certification.

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The county shall include the following in the CCPR;

A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TTD or California Relay Service, shall be available for all individuals.

Sonoma County MHP has a 24 hour phone line that is answered by a live person.

The MHP policy is to utilize a bilingual staff member to provide interpretation services whenever needed. If staff are available the MHP uses other resources to provide interpretation. These other resources include:

- CTS Language Line
- Individual contracts for Cambodian
- CA RELAY TDD

- Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.

  - Protocol to use a bilingual staff person whenever possible to take the call
  - If no bilingual staff person is available, staff use the Language Line

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

3. Description of protocol used for implementing language access through the county's 24-hour phone line with state toll-free access.

All staff have been trained and are given written instructions to access the CTS: Language Line.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters and Policy No: VII.E.5. Process for Distribution of Translated Materials addresses this issue.

C. Evidence the county/agency accommodates persons who have LEP by using bilingual staff or interpreter services.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters and Policy No: VII.E.5. Process for Distribution of Translated Materials, MHP – 08 Instruction Sheet: How to Request Interpretation Services with CTS Language Link and MHP – 08 Communique ASL Interpreter Request Form addresses this issue.

D. Share historical challenges of efforts made on items A, B, and C above.

Sonoma County MHP continues to be challenged to recruit, hire, train, and retain enough bilingual staff, at all levels of the organization, to meet the need of our threshold language.

E. Identify county technical assistance needs. N/A

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

The county shall include the following in the CCPR Modification (2010):

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for languages spoken by the community.

Sonoma County Behavioral Health Division's Policy No: VII.E.5. Process for Distribution of Translated Materials and Policy No: MHP – 8 Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters address this issue

Every Sonoma County MHP service provider is required to post instructions regarding Free Language Assistance Services prominently in their office.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded. The document below can also be found at the following link: http://www.sonoma-county.org/health/publications/pdf/informing/free-language-assistance.pdf

Policy No: VII.E.5. Process for Distribution of Translated Materials addresses this issue.

Sonoma County Behavioral Health's Policy No: MHP – 8 Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

Every Sonoma County MHP service provider is required to post instructions regarding Free Language Assistance Services prominently in their office.

C. Evidence of providing contract or agency staff that are linguistically proficient in the threshold languages during regular day operating hours.

Sonoma County Behavioral Health Division's Policy No: VII.E.5. Process for Distribution of Translated Materials and Policy No: MHP – 8 Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters.

D. Evidence the counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g. formal testing).

Because the competition for attracting and retaining skilled workers has increased significantly particularly in the areas of law enforcement, health professionals and for bilingual candidates, Sonoma County provides bi-lingual pay to certified bi-lingual staff working in specific, bilingual designated positions. In order to receive this premium staff must meet the established job qualifications and who also meet the County's bilingual certification requirements. For those who meet those requirement and who speak a necessary language, such staff receive a "bilingual premium" ranging from $0.90 per hour to $1.15 per hour, paid on all hours worked.

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.

The county shall include the following in the CCPR Modification (2010):

A. Policies, procedures, and practices that include the capacity to refer, and otherwise link clients who do not meet the threshold language criteria (e.g. LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

B. Provide a written plan for how clients who do not meet the threshold language criteria are assisted to secure or link to culturally and linguistically appropriate services.

The MHP maintains a policy to ensure that all client and MHP contact providers link non-English speaking clients to culturally and linguistically competent mental specialty mental health services regardless of language spoken. Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

C. Policies, Procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:

1. Prohibiting the expectation that family members provide interpreter services;

2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and

3. Minor children should not be used as interpreters.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

V. Required translated documents, forms, signage, and client informing materials

The county shall have the following available for review during the compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

C. Consumer satisfaction survey translated into threshold languages, including a summary report of the results (e.g. back translation and culturally appropriate field testing).

- Sonoma County MHP uses the Performance Outcomes Survey as provided by DHCS.
- All additional surveys administered by Sonoma County MHP are provided in both Spanish and English

D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g. back translation and culturally appropriate field testing).

The practice of Sonoma County MHP is that for translated documents to be proof-read by at least two bilingual staff to ensure accuracy, and accessibility.

E. Report mechanism for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

Documents are reviewed for appropriate grade reading level.

CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR Modification (2010):

A. List client driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences. Infrastructure to Sonoma County's client driven/operated recovery and wellness programs are provided by 2 large non-profit organization: Goodwill Industries of the Redwood Empire and West County Community Services.

Goodwill Industries of the Redwood Empire
- Wellness and Advocacy Center – Santa Rosa
- Interlink Self Help Center – Santa Rosa
- Petaluma Peer Recovery Program – Petaluma

West County Community Services
- Russian River Empowerment Center – Guerneville

II. Responsiveness of mental health services

The county shall include the following in the CCPR Modification (2010):

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community based, culturally appropriate, non-traditional mental health provider.

- As required by DHCS, Sonoma County MHP provides a Provider Directory to all new clients which provides information regarding types of services available, populations served, and/or linguistic capabilities.
- Sonoma County Behavioral Health contracts with a number of community based organizations who provide non-traditional mental health services.

Agency/Organization ↓	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
Latino Service Providers/Latinos		√	√	
Sonoma County Indian Health Project/ Native Americans		√	√	√
Positive Images/LGBTQQI		√	√	
Community Baptist Church Collaborative/ African Americans		√	√	

Santa Rosa Community Health Centers/ Communities of Color		√	√	√
Alliance Health Center/Latinos	√	√	√	√
West County Health Services/ LGBTQQI		√	√	√
Alexander Valley Health Center/Latinos	√	√		

B. Evidence that the county informs clients of the availability of the above listing in the member services brochure. If it is not already in the member's services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

Sonoma County MHP provides each beneficiary with the DHCS required, Guide to Medi-Cal Mental Health Services. It is also available in English and Spanish on the Sonoma County Behavioral Health website at: http://www.sonoma-county.org/health/publications/medi-calinforming.asp.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (Counties may include a) Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services; or b) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)

Informing Materials in English and Spanish are available on the Sonoma County Behavioral Health website at http://www.sonoma-county.org/health/publications/medi-calinforming.asp.

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas;

- SCBH's Access Team is located on the main behavioral health campus on Chanate Road in Santa Rosa. In addition to its familiarity to all county residents and all community partners by virtue of the main campus having been located here for more than 30 years, it is also on the main bus line, and is centrally located.
- The Behavioral Health Division's long-term plan is to move its central Santa Rosa services to the southern part of Santa Rosa. Not only is this area in the heart of the Latino community, it is also where the many Medi-Cal beneficiaries reside. It is also accessible from all parts of Sonoma County given its proximity to the major highways.
- The county has had local behavioral health centers in the southern, northern, eastern and western parts of the county for decades, to assure access to services for all county residents.
- The hours of operation are generally 8 AM – 5 PM, Monday through Friday. However, there are five Full Service Partnerships that provide services beyond those hours, as needed,

including weekends.

- As part of the MHSA planning process, it was decided to make outreach activities more accessible. As an example, CIP regularly visits homeless shelters at least once per week in the evenings. They provide staff for health fairs on some weekends and evenings as well.
- The MHSA planning process for consumer-operated services reviewed access for consumers, and determined that there should be consumer-run services in other parts of the county, for better access. As a result, an additional center was built in Santa Rosa, a new one was added in Guerneville (Western Sonoma County) and most recently a center in Petaluma.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs);

All county-owned facilities have disabled access. Many have upgraded their waiting rooms to be more client and culturally-friendly and inviting.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

- As part of the MHSA planning process, in order to provide more service to the Latino population, it was decided to co-locate services as much as possible with the community health centers (FQHCs and Indian Health Project). The MHP funds behavioral health staffing, including psychiatrists, clinicians, and case managers for the community health centers and contracts with them to provide appropriate behavioral health services.

III. Quality of Care: Contract Providers

A. Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

- All Mental Health contracts include specific language regarding non-discrimination in employment.
- All Mental Health contracts include specific language regarding compliance with all Federal, State and County requirements for providing service – and this includes being able to provide linguistically-competent services.
- PEI contracts were awarded to specific cultural and ethnic groups to provide more services to their communities. These include contracts to Community Baptist Church (African-American), Positive Images (Gay/Lesbian/Bi-Sexual/Transgender), and NAMI.

IV. Quality Assurance

Requirement: A description of current or planned processes to assess the quality of care provide for all consumers under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of service to consumers including, but not limited to, the following:

The county shall include the following in the CCPR Modification (2010):

A. List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

- All trainings are to include objectives related to cultural competence, which are then analyzed.
- The Quality Improvement Committee developed a consumer-driven consumer satisfaction survey, using client focus groups to first determine survey questions that are important to consumers. Action plans were developed based on issues identified. Surveys of consumers and family member satisfaction are conducted periodically.

B. Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

The CBMCS survey was given to staff in 2010 and 2012. Results were analyzed by an outside consultant. Based on the results, focus groups were held to gather additional input from staff. Outcomes from the surveys and focus groups are being used to develop an action plan around addressing culturally related issues within the division. The next round of surveys are scheduled to take place by the end of 2017.

C. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non Medi-Cal client Grievances and Complaint/Issue Resolution Process data is analyzed and any comparison rated between the general beneficiary population and ethnic beneficiaries. A copy that outlines the Grievances and Complaint/Issue Resolution Process can be found at this link: http://www.sonoma-county.org/health/publications/pdf/informing/client-rights-and-grievance-appeal-process-and-form.pdf

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